mental health digest

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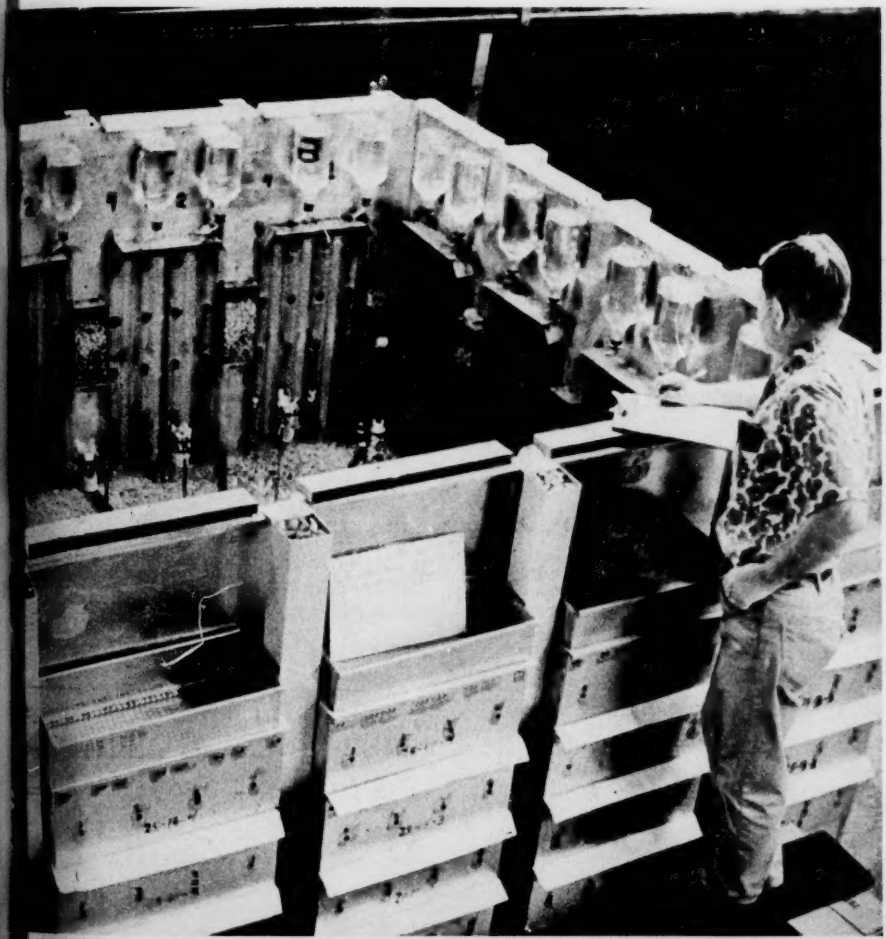

cover story

In recent years there has been an upsurge of interest in the total environment of man. Architects, city planners, as well as professionals in the mental health field, are studying the impact of the environment on man's quality of life and on mental illness and mental health. As described in the first digest in this issue, "studies of animals in their natural setting and in experimentally structured habitats provide insights having implications for the human scene."

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The *Mental Health Digest* is a monthly publication designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view. It contains condensations of material selected from the current mental health literature.

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Design for Mammalian Living

JOHN B. CALHOUN

Studies of animals in their natural setting and in experimentally structured habitats provide insights having implications for the human scene. I shall outline some major aspects of environments, with comments relating to my studies as to how these aspects modify the behavior and social organization of the animals exposed to them.

Time Apportionment

The modern mammal is a dual binary time programming machine reflecting five levels of evolutionary development. At each level there are two types of generic behavioral states added to the prior ones. There is the Type 1, or incorporating state, in which the individual takes into itself the "nutrients" for development, whether these be food, experiences, or concepts. The Type 2, or contacting behavioral state, involves more active "moves" to make contact with the environment, although this movement may simply be experiencing, acquiring information, or bringing mental associations into relationship. Any shift from a contacting behavioral state to an incorporating behavioral state represents a creative transformation, provided it enables the individual to develop beyond its present condition of existing.

Level 1 of evolutionary development is the early simple chordate level. At this time two simple behavioral states—absorbing and drifting—encompassed 50 percent of each animal's time. With the piscine epoch, two states—drinking and locomoting—were added, each of which consumed twice as much total time as the behavioral states upon which they were superimposed. At the amphibian-reptilian epoch, eating and copulation were added along with a more active and complex grooming or investigation of self and environment. These states consumed twice the time as the comparable states arising in the prior epochs. By a similar process, incorporating and contacting dream-type states and then subconscious prolonged deep sleep came to characterize the paleomammalian and neomammalian epochs; the former transformation culminating 65 million years ago, and the latter seeing its final transformation in this century. This tentative formulation of modern mammals as time-apportioning machines represents a poetic or intuitive extension from "hard" experimental data.

The coming century is critical for human evolution. It will see the termination of the human experiment of the past 40,000 years, during which man went beyond his biological heritage to learn how to elaborate conceptual space and escape the bondage of physical space. Expanding conceptual space has permitted a continuing expanding population. With each doubling of population there has been a doubling of conceptual space. Ideas and codes have evolved which enable resources to be mined more effectively and new social roles to be elaborated. By adequate role definition, man has been able to maintain a degree of reward from social living, comparable to that of his biological heritage which demanded life within small relatively closed bands.

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This process will terminate during the next century with an optimum human world population of nine billion. Beyond that time a continuing expansion of human potentialities will require that the population decline. The inflection point will also mark a time after which the human brain will be unable to process information sufficiently rapidly, or generate the new creative concepts necessary to continue the process of expanding potentialities. Present computers represent prostheses to our brains. Our use of them represents a new category of Type 2 behavioral state which places us more effectively in contact with items of the informational environment. We may also look forward to having additional prostheses for our brains which will enable us to create new concepts more effectively. Our use of these prostheses will represent a new Type 1 category of behavioral states. Man will have been transformed from a biological and cultural species to a biological, cultural, and prosthetic species representing a sixth level of neural functioning.

Let us now turn to some simplistic insights from research. (The word at the beginning of each section designates a generic concept of a functional requirement for living which environmental design affects.)

Protection

Protection in the ecological sense implies buffering from extremes of environmental conditions, not avoidance of fluctuation. Many mammals construct dens or burrows, build nests, or use crevices in rocks or logs, or seek caves. These serve as buffers from extreme environmental change, provide a place of retreat for rest, rearing young, or for temporary respite from too frequent contact with associates.

The term "harborage" refers to protected sites. Where I have allowed a larger population to develop, the policy has been to provide a large number of sites, several within the range inhabited by any individual. Some harborage sites are used more than others. The differential usage serves as a key for seeking factors of the environment modifying its utility for the inhabitants. When populations are small, practically all individuals rest within the harborage sites. As population increases, a few individuals avoid any available sites. Animals which resort to living in public space are of low social rank, exhibit deviant behaviors, and move about only to obtain food and water. Even when stationary they keep their eyes closed and heads averted from associates. The prevalence of such individuals in public space serves as an indicator of the degree to which the environment is inadequate. Marked overcrowding is this sense may develop even when many harborage sites are infrequently utilized.

Arousal

Isolated rats have been studied in a habitat where a compartment contains food and water and a place for rest. A long, narrow, unstructured alley is attached to this compartment. Each rat will engage in bursts of locomotion, despite the fact that the alley is unstructured. I designate the activity as "spontaneous locomotion." Finding a resource or responding to a stimulus during locomotion does not indicate searching for something. One item in the home compartment is a food hopper. If additional hoppers are scattered at equal intervals, the rat will eat from each of them. More important, it will make many trips into the alley although mere acquisition of food would not have required the rat to leave home.

If the hoppers are arranged so that the rat can transport food to its home to form a cache, the number of trips increases. All hoppers are visited, although the frequency decreases with distance from home. Were this a search problem, the simplicity of the searching would have led to food being removed only from the hopper nearest the home. Environmental structuring merely increases that functioning of the central nervous system that initiated episodes of locomotion; the probability of terminating the episode remains constant no matter how long it has already persisted.

When novel stimulus situations are introduced, they result in a heightening of spontaneous locomotion. The number of such trips decreases until after a few hours an approximately normal level has been reachieved. If too much novelty is introduced simultaneously, the rats often refuse to enter the alley.

Availability

In the natural setting distribution of such resources as food may be dichotomized into two types. In one case, items are distributed universally through the range of each individual. Were the animal to respond to every item, it would deplete the reserve nearest its home. Avoiding such maladaptive behavior has led to the evolution of the ability to ignore relevant stimuli while on outward spontaneous locomotor excursions. Responses to resources at terminations of excursions lead to a "topography" of density of responses, greatest nearest the animal's home and decreasing with increasing distance. A uniform impact on resources over all the terrain requires overlap of the ranges of adjoining individuals. To develop a large stable system of overlapping ranges, each animal's home must be near the center of its range. This need to have a homesite at the center of each range has been a major impetus in the evolution of the ability of animals to construct homes. Overlapping of ranges brings neighbors into contact with one another. This contact among neighbors culminates in compact social groups which on the average contain 12 adults.

In the second case, items are scattered and unpredictable as to their position. Predatory mammals represent the type whose resources are so distributed. They have several subranges with a home in each. From each homesite the predator roams about the surrounding subrange, until diminishing returns dictate moving on until the circuit of visiting the subranges is completed and the circuit starts anew. A gathering-type animal needs a single home, a predator must have seven.

There is a third pattern of distribution of resources in which several, but not many, sites occur within the range of each individual. Because of some consequences of their distribution, it is more appropriate to discuss it under *Effort* and *Contact* rather than *Availability*.

Effort

In designing a habitat to simulate the urban setting of wild rats commensal with man, I placed artificial harborage sites nearer than others to the single central source of food. Rats living closer to the food exhibited a higher social status than those living farther away. Social status was equated with ability to maintain high dominance status and to rear young successfully. Socially lower ranking rats exhibited a decreased ability to construct burrows and nests.

I also arranged harborage sites as horizontal or vertical series with re-

spect to distance from food and water. This introduces an economic factor; the farther an animal lives from the resource sites, the more energy it must expend. The farther a harborage site is from other resources, the less frequently it will be visited. This means that one cannot judge the adequacy of a habitat by the number of such items as harborage sites. Their accessibility in terms of effort must be considered.

Extent

These habitats have been physically closed systems. There arises the necessity of assessing the degree to which the space harmonizes with the nature of the kind of animal. One habitat designed for mice illustrates a criterion for judging it to be too small. It had an unstructured floor space of 225 square feet. At one side there was a smaller pen with a single door which provided access to food, water, and nesting material. On the opposite side was a stand containing two shelves at each of four levels from the floor. A steep ramp provided access to one end of each of the eight shelves.

"Home range" is that space encompassing the normal ranging movements of an individual or members of a group. Where too many trips terminate at the boundaries, it may be judged as too small. In one of my mouse habitats, four harborage boxes were placed along each of eight shelves. A nearly vertical ramp connected one end of each shelf to the floor. There were two shelves at each of four distances from the floor where food and water could be found. Mice often defecate at the end of excursions. Number of feces decreased with increasing distance from the ramp end of the shelf. However, an increase in number of feces occurred at the end of the shelves farthest from the ramp. This indicated that the shelves were insufficiently long to conform to normal ranging movements. Excessive use of peripheral portions of enclosed habitats is common for farm and zoo animals. Vertical structuring is effective in making an enclosed area more nearly optimum, since it requires several times the energy to cover a unit of vertical distance in comparison to that distance on the horizontal. Likewise, placing barriers between two points increases the travel distance and makes a given amount of floor space larger.

We define a "cell" as that area which is sufficiently large to encompass most episodes of spontaneous locomotion and contains all major resources. An isolated cell, or several cells with routes of communication among them, form "universes." Rats and mice learn the routes to adjoining cells and from time to time visit them. This behavior produces a redistribution of the population where, at its present distributional steady state, the number of animals present in each cell is proportional to the number of cells to which it is connected.

Identity

To the extent that an animal is alone during its travel, it develops an identity with objects encountered. Incursion of another animal into this "personal" space generates anxiety and may precipitate a fight in which the winner is the individual which has developed the greatest identity with surrounding objects. Other individuals may be incorporated into the extended ego boundary or territoriality. When this occurs these individuals are in part treated as physical objects. They are herded or maneuvered into more restricted routes. The dominant male in a region frequently patrols his terrain. In extreme cases subordinate

males become immobilized at points requiring the minimum movement to reach food and water.

Expanding the opportunity for identity formation requires an environment rich in the number, kinds, and complexity of objects and situations. On an intuitive basis such richness will retard the stultifying consequences of the trend toward complete predictability of all physical and social items and events. When we reach the human level these tendencies become transformed. Ideas replace physical objects. Opportunity to acquire ideas, concepts about reality, extend ego boundaries as experience with them produces a feeling of personal identity with them. Actions by associates which contradict these images of reality lead these individuals to be rejected. On the positive side, the primitive defence of territory becomes transmuted into commitment to attain emerging images of reality. No design of the physical environment for man can be effective unless it is coordinated with the design of the opportunity to acquire and create concepts, and with the design of relationships among inhabitants which promote commitment to transforming images into action furthering the meaning of information for survival.

Choice

I once built an enclosure which would permit a few colonizing wild Norway rats to develop into a population including social subgroups. Study of rats in backyards, adjoining houses, etc. provided important clues. Rats build trails between major points, such as places of shelter, food, and water. Some trails connect points directly, but along such a direct route other trails branch off. When I constructed a habitat, barriers and resources were placed so that at any point a rat would have a choice of routes. The rats improved upon my design by developing a more complex web of trails.

This opportunity for choice of route reduces the stressful contacts between individuals. However, spatial communication networks have a broader implication. Burrows form a network of short tunnel segments with side compartments for nests. If rats initiate construction adjacent to a vertical surface such as a fence, their thigmotropism leads to the development of a long tunnel with many short side branches ending in nest cavities. Network burrows produce colonies whose members are of "high social class" in the sense of holding high rank in the social hierarchy, and of exhibiting the capacity to repair burrows and nests, as well as being able to rear young successfully. Inhabitants of linear burrows exhibit opposite characteristics and do not exhibit the normal repertoire of interpersonal behavior. If circumstances force reduced status on inhabitants of a network burrow, they lose the capacity to maintain its web-like form; the burrow becomes fragmented or linear and is kept in poor repair. There appears to be a cause-and-effect relationship between the degree to which the physical environment provides network communication and the degree of social integration of the group and functional effectiveness of individual behavior.

Contact

The evolution of mammals took place primarily in two-dimensional space. Most individuals led solitary lives. Gradually attachment to a home-site near the center of the range developed. Evolutionary "pressure" required reduction of antagonisms and sufficient overlap of ranges to produce

an equal intensity of impact on resources across all space inhabited by the species. This overlapping brought neighbors into contact which led to formation of groups. This proceeded rapidly, as evolutionary time is measured, through an initial phase of seven until its replacement with twelve as the optimum group size.

The meaning of optimum number lies in the fact that once a species has persisted at a particular average size for its contained groups, the members will evolve a physiology and behavior that will enable maximizing the number of satisfying social relations. For most species, including man at his primitive hunter-gatherer stage, the number of individuals inhabiting a particular area and the number of meaningful contacts each individual enjoyed were consonant with each other.

As long as intensity of social interaction remains constant, any increase in group size above the optimum will culminate in increasing frustration and reducing gratification from social living. Most animals have sufficient plasticity to enable them to reachieve optimum gratification by reducing the intensity or duration of interaction whenever their group size increases above the optimum.

Spatial limitation of resources such as roosting caves for bats, breeding beaches for seals, or water holes for ungulates has led to dense aggregations. Evolution has culminated in adaptation to a herd way of life. One price has been a reduction of intensity of social interaction accompanied by a heightened ability to "block out" awareness of associates.

Human cultural evolution has followed a different course. It has accommodated to increase in density by elaborating social roles where codes of behaving limit the number of others with whom it is appropriate for an individual to interact. A major function of the design professions is to provide an environmental structure that will promote a frequency of meaningful social interactions comparable to that which held prior to cultural evolution. Appropriate design of the physical environment for man cannot proceed independently from design of the social environment which fosters increased diversification of social roles as total numbers of individuals increase.

Change

Most animals avoid a novel situation. This has been termed the "strange object reaction." When confined in a novel situation, animals exhibit such signs of emotionality as defecation and urination. They also exhibit an increase in undirected locomotor activity. Once a normal level has been achieved, adjustment to the novel situation has occurred. We know little about the implications of frequent changes in the composition and configuration of the environment, other than to suspect that the heightened state of arousal must bring the individual into more frequent contact with normal components of the environment.

If the physical environment remains completely predictable, all uncertainty applies to the social environment. An individual will experience difficulty in knowing whether associates are ready to respond appropriately to its advances. During the normal course of social living this failure to recognize receptivity of associates culminates in the average individual engaging in as many frustrating as gratifying interactions. Where the

physical environment remains predictable, selection, whether natural or cultural, may be expected to culminate in the ability of individuals to produce signals alerting associates to their state of receptivity.

Both natural and cultural evolution suggest the strategy for introducing and maintaining change within the environment. Both have introduced crises and uncertainty, which give survival value the ability to cope with complexity. Change over time is an aspect of complexity. The most favorable environment is one that will progressively enhance complexity coping.

Transition from the Physical to the Conceptual

With man's emergence as a cultural animal, he learned to create new concepts more rapidly and to pass them on more effectively to succeeding generations. This growing conceptual space permitted the human species to circumvent the limitations on his numbers affecting all other species. If we are to survive and continue the human experiment, there must be more effective collaboration between design professions concerned with creating physical environments and those concerned with conceptual environments.

A Treatment-Focused Geriatric Program in a State Mental Hospital

NATHANIEL S. LEHRMAN and JACOB H. FRIEDMAN

In State mental hospitals, the transformation of geriatric services to active treatment units is taking place throughout the country. Our purpose is to describe the present modes of operation at Bronx State Hospital, where many of these changes have occurred, and to outline some of our plans.

Screening Clinic

We have a program whereby community sources—hospitals, physicians, social workers, and families of the aged—can call our admissions clinic to discuss geriatric problems. A social worker or a nurse takes the call and assesses the situation so that referral to the proper resources can be made. If desirable, an appointment is made for the patient to be seen by our psychiatrist. Prior to this appointment, a medical workup will have been completed.

When a patient comes to the hospital, his family is interviewed in depth by the social worker. The psychiatrist reviews the history, physical findings, and medical report, and examines the patient psychiatrically; then the best disposition plan is determined. Some patients are admitted as inpatients, others to the outpatient clinic where they are followed by the psychiatrist, being seen several times a week until the acute crisis is over, and then with diminishing frequency. Some have been admitted to the day hospital, but our attempts have not been successful. We had been using our recreational therapy program as a basis for referral to day hospital status, but patients admitted fresh from the outside found it too distressing. We are now seeking to incorporate geriatric programs within the day hospital established for younger patients.

Admission to the Hospital

All patients 65 or older are sent to the geriatric admissions ward, where a psychologist and a social worker (full time) and a psychiatrist and a general physician (part time) lead the professional staff. The admitting psychiatrist will have started a medication program, a program modified as daily observation of the patient requires. Treatment modalities include: therapeutic community meetings for the entire ward staff and patients at least once weekly, and frequent small group meetings pegged to the patients' levels of capability and involving activity therapy and recreational therapy. There is an active recreational therapy program. The occupational therapy program is relatively conventional on the admissions ward, but is modified significantly for regressed patients on other wards. Some individual therapy is given, but families are dealt with intensively. Attempts are made to have staff members meet at least intermittently with the patients and their families so that the relationships are preserved. Home leaves for weekends are started soon after admission, unless contraindicated.

Intensive Treatment Ward

A geriatric intensive treatment ward is functioning. Patients who have been in the hospital a long time and whose habits of self-care and personal re-

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sponsibility have tended to atrophy, become engaged in small-group and therapeutic activities, with attention focused on their assuming responsibility for an ever-increasing fraction of the ward chores. When these patients have improved, they are transferred to our "hotel ward." Here the patients are free to come and go as they please, make their own clinic appointments for psychiatric follow-up and for investigation of medical complaints, and cook many of their meals. The "hotel ward" was established because of the paucity of community facilities for geriatric patients long in the hospital and able to handle almost all their own needs, but requiring some social support, at least during the post-hospital period.

In addition, there is an active geriatric work-for-pay program, in which some 31 in-hospital patients have been involved. Contracts have been obtained for piece work and the patients are paid at the same rate as are employees in the community.

Regressed Patients

In order to reverse as many regressive changes as possible, we instituted a reality orientation program and a sensory training program.

In the *reality orientation program*, patients are regularly exposed to classes for half an hour a day, where they are drilled on the date, on their names and the names of those around them, on colors, and on the names of objects. They are encouraged to react to one another in terms of present and past experiences. All wards have calendars posted conspicuously, and staff members are encouraged to remind patients of such items as where they are, and the date.

The *sensory training program* is based on the stimulation of individual sensory modalities in an orderly fashion by the therapist working with five or six patients. Differences in odor between coffee and mint are demonstrated, as are various color and shape differences. After sample modalities are dealt with, combination modalities are presented.

Occupational and recreational therapy have been modified to meet more adequately the needs of regressed patients. For example, the simple bouncing of a ball, or passing it around, is an important recreational activity.

Community Activities

We are not limited to what happens within our walls. There is a liaison with Bronx House, a community house approximately a mile away, to which our patients go for meetings, concerts, parties, and group discussions, and their clients come to the hospital to mix with and to entertain our patients. We have also established an association with the Emmanuel Camps, an affiliate of Bronx House, and are planning a program whereby some 30 patients can spend two weeks at a summer camp with healthy aged persons in that program. We have under discussion the construction (also in cooperation with Bronx House) of a geriatric residence, and a geriatric community and mental-health center. In the residence, about 15 percent of the places would be reserved for our released patients. All necessary medical, psychiatric, psychological, social, and community supports would be built in.

After Release

Many of our patients are suitable for nursing homes and are released there. The patients are placed under convalescent care, and we stand ready to treat them should they become upset; this includes visiting them in the nursing home, or re-admitting them

here. We have obtained two pairs of apartments in apartment houses in the Bronx and Manhattan, where 16 ex-patients live. With mutual support and one staff member temporarily spending her working day with them, they have been able to live happily and successfully in the community. Medical, social, and community-house supports have been built into these programs.

Arrangements have been made to transfer 60 patients to a newly opened residence for the healthy aged. We are assisting in the establishment of programs in recreation and occupational therapy, and supplying a ward staff to aid during the transition. The patients are on aftercare status, with our hospital continuing its psychiatric responsibility. A careful evaluation is made of all facilities to which patients go from the hospital, including their own or their families' homes; a visit to the place where the patient will reside is mandatory before release.

Ward Staff Attitudes

These changes could not have taken place without attitudinal changes in the staff. These, in turn, were produced on each ward by regular meetings of both ward and professional staff, by specific activity, recreational and occupational therapy programs, and by the weekly admissions clinical case conference. Here, psychiatric, psychological, medical, and social viewpoints converge in the evaluation of a particular patient. Conducted on a professional level (complex terminology being translated into simple language), the conferences have aroused the interest of the ward staff concerning the patients' potentials, and how to help the patients as human beings rather than merely as bodies that need tending.

Systematic Desensitization Versus Implosive Therapy

CURTIS L. BARRETT

Two learning-theory-based therapies call for opposed operations. These are systematic desensitization therapy and implosive therapy. In systematic desensitization therapy, relaxation is used in reciprocal inhibition of small doses of anxiety that may be aroused by a hierarchical arrangement of stimuli. Care is taken that the subjects experience little or no anxiety as they imagine elements of feared stimulus events.

Implosive therapy assumes that extinction of a negative emotional response to objectively neutral stimuli will proceed most rapidly when subjects are exposed to a conditioned stimulus without reinforcement. Use of a gradual approach invites reinstatement of the response to the conditioned stimulus in accordance with the conservation of anxiety hypothesis. Therefore, the subject is instructed to imagine scenes suggested by the therapist until some sign of reduction in the anxiety elicited by the scene occurs. Then scenes that produce more anxiety are suggested. This process is continued until the scenes suggested by the therapist no longer elicit anxiety.

A practitioner's choice of either systematic desensitization therapy or implosive therapy on theoretical grounds would be premature since both therapies must await demonstration of the adequacy of their underlying theories. Choice on the basis of effectiveness also would be difficult since both have been shown to be effective.

My study was conducted to provide a comparison of the effectiveness and the efficiency of systematic desensitization therapy and implosive therapy in reducing the same disordered behavior. Fear of harmless snakes, as it occurs in otherwise normal adult human beings, is the disordered behavior. Efficiency of a therapy is defined as time required for treatment.

Thirty-six subjects, eight males and 28 females, were selected according to the criteria: demonstrated fear of a harmless snake, absence of severe emotional disorder, verbalized reason to overcome fear of harmless snakes, and commitment to participate in up to 15 hours of therapy.

Several measures of fear were administered by an experimenter who participated in no other aspect of the experiment.

Persons who were afraid of harmless snakes were sought in graduate and undergraduate classes, nursing schools, and from the public via newspaper publicity. Those whose fear appeared genuine received pretreatment testing. One experimenter introduced the subjects to a second experimenter who asked the subjects to come to a room in which, 15 feet from the door, there was a caged live 6-foot black snake. The subject was asked to approach, touch, and hold the snake. The subjects who neither held nor touched the snake were given the Minnesota Multiphasic Personality Inventory. Those whose MMPI profile appeared to be normal were referred to an experienced clinical psychologist. If no evidence of present or past emotional disorder other than snake phobia was found, the subject was accepted and assigned randomly to one of three groups: systematic desensitization therapy, implosive therapy, or control group.

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The subjects assigned to the control group were told that they would be contacted concerning the next step in their "therapy." Next, they received a letter that arranged for posttreatment testing after eight weeks. They were contacted similarly to arrange for a follow-up testing after six months. After follow-up testing, a second experimenter explained the experimental procedures and the function of control groups. Then he offered the subjects treatment for the phobia at the University of Louisville Psychology Clinic.

The subjects assigned to systematic desensitization therapy received four training sessions and up to 11 therapy sessions. The criterion for termination in fewer than 11 treatment sessions was presentation of the hierarchy twice without the subject signalling disturbance. The systematic desensitization therapy subjects received the post- and follow-up testing that the control group subjects received.

The subjects assigned to implosive therapy received two 50-minute clinical interviews followed by up to two sessions of implosive therapy which were of unspecified duration. Near the end of the second interview the subject practiced neutral imagery such as walking into a store. Then, a scene such as confronting a snake while climbing a tree, which initially was thought to arouse maximum anxiety in the subject, was presented until the subject showed some diminution of anxiety. Then a new scene (e.g., being enveloped in a python's coils) was presented until it too ceased to elicit anxiety. Scenes depicting helplessness, bodily harm, envelopment, and being devoured by huge snakes were commonly used. The only departure from standard implosive therapy procedure was exclusion of psychodynamic material. The termination criterion was the same as that for systematic desensitization therapy: presenting the subject's most frightening scene twice without his indicating disturbance ("fear," "anxiety"). The subjects received the same post- and follow-up testing as the systematic desensitization therapy and control group subjects.

All sessions were tape-recorded and rated by two clinical psychologists and one experimental psychologist, trained in systematic desensitization therapy and implosive therapy. The rating procedure required identification of randomly selected 5-minute excerpts as systematic desensitization therapy or implosive therapy operations. The raters identified both therapies correctly.

Considering treatment time only, implosive therapy on the average was completed in 41 percent of the time required for systematic desensitization therapy. Comparing treatment plus training time, implosive therapy was completed in 45 percent of the time required for systematic desensitization therapy.

The therapies were found to be equally effective in reducing snake phobic behavior of otherwise normal adult human beings. Both overt avoidance and verbal reports of fear or anxiety were reduced. The therapies did differ in their efficiency since implosive therapy was complete in 45 percent of the time required by systematic desensitization therapy. Control procedures resulted in less reduction in phobic behavior. Thus, implosive therapy would appear to have been the more efficient of two equally effective methods.

Results of additional analyses indicate some qualification of these findings. These data indicate that the effect of systematic desensitization therapy was consistent across subjects and

that it continued until the last point of testing. The effect of implosive therapy was less consistent. Some subjects improved markedly and maintained their improvement. Others improved but, at follow-up, showed avoidance behavior that was little different from their pre-treatment behavior.

The major findings are consistent with results of previous research, but some reactions have not been reported in the behavior therapy literature. For example, during systematic desensitization therapy, one subject showed considerable distress and reported that "wavy lines" that she visualized had turned into moving, frightening snakes. Similarly, a systematic desensitization therapy subject began sobbing during visualization of a scene in which she previously was comfortable. She reported that the scene, which included a snake in a closed cage, had developed suddenly and unexpectedly into a frightening one in which the snake came toward her.

Similar reactions to scenes during implosive therapy, of course, were expected. As required by implosive therapy, instructions for the subject to continue imagining frightening scenes were given when the subjects showed disturbance and, after a time, the subject ceased to show disturbance. However, two subjects in the implosive therapy group showed a disturbance between sessions. One reported that after therapy she consistently visualized snakes when she shut her eyes, that her sleep was disturbed, that she could not attend lectures, and that she was unwilling to participate in the second session. She was persuaded to continue and, at post- and follow-up testing, held the snake. A similar report was given by a nurse who said that her work was disrupted by her crying when she thought of snakes. She too participated in the second session and was successful at post- and follow-up testing. Results such as these underline the criticisms of behavior therapy by indicating that the operation of instructing subjects to imagine scenes does not lead necessarily to reliable responses.

Findings support the view that implosive therapy is an effective, efficient behavior modification technique for use with phobias. The results make more explicit evidence for systematic desensitization therapy as an effective technique that has a consistent and continuing effect across subjects and across time. However, disturbances reported by both systematic desensitization therapy and implosive therapy subjects during imagery again raise the question of what subjects actually do following instructions to "imagine a scene."

Chlorpromazine Slows Decay of Visual Short-Term Memory

George C. Stone, Enoch Callaway III, Reese T. Jones, and Tom Gentry

Chlorpromazine, scopolamine, and pentobarbital all share sedative actions, while chlorpromazine and scopolamine also share anticholinergic action. Yet the drugs are dissimilar—only chlorpromazine is effective in the treatment of schizophrenia. We studied the effects of chlorpromazine, scopolamine, and pentobarbital on visual short-term memory. The effects on the performance of introverts and extraverts were also examined.

Subjects were 40 male students, selected from prospective subjects on the basis of the 20 highest and 20 lowest scores on the Extraversion scale of the Maudsley Personality Inventory. They were divided into four drug groups of 10, five introverts and five extraverts to a group. Subjects in each group received one of the following: chlorpromazine (50 mg), scopolamine (0.6 mg), pentobarbital (100 mg), or placebo.

Subjects were presented with nine-letter (3 by 3) matrices flashed onto a projection screen for 1/15 second. Only consonants were used. Subjects received 24 practice trials. Then, three blocks of 18 presentations were run. Subjects were instructed to guess if they were not sure. Trials were run approximately every 5–10 seconds with a short break between blocks.

The mean number of letters identified by introverts (13.5) and extraverts (14.8) did not differ significantly. The interaction of introversion-extraversion with drugs was not significant either, so subjects were pooled into a single group for each drug.

Three-way analysis of variance with repeated measures showed a significant difference among the drug treatments. Scopolamine, pentobarbital, and placebo did not appear to differ, and a separate analysis showed this to be the case. These three treatments were therefore pooled and tested against the mean for chlorpromazine. This difference was significant. Chlorpromazine improved performance.

Three explanations seem plausible: First, chlorpromazine enhances habituation. If habituation is an inhibitory process related to the decay of the visual short-term memory trace, then chlorpromazine should speed short-term memory trace decay. Second, chlorpromazine increases filtering. In this case, chlorpromazine would depress interfering poststimulus "noise" and allow retrieval of data from visual short-term memory for a longer period. Finally, chlorpromazine delays the initiation of motor action; e.g., it suppresses avoidance behavior without reducing escape behavior. If the removal of visual short-term memory trace were a positive action, and chlorpromazine produced a delay of that action, then chlorpromazine would protect the short-term memory trace.

The data allow us to reject the first alternative. Further research is needed to permit a choice between the second and third alternatives.

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Poverty, Mental Health, and the Church

James R. Harris

Psychiatry and religion are middle-class institutions. Since Freud in the 1890s, psychiatry and psychoanalysis have concentrated on the explication of the internal psychodynamics of middle-class Western man and the biological aspects of man's behavior. Little has been done in social and community psychiatry; many people in need of service have been neglected. During the same period, the Protestant Church (and to a degree the Catholic) abandoned the lower classes in the center city, and moved into the middle and upper-class suburbs. The minister and psychiatrist have lost contact with the poor. Religion has relegated the poor to missions and splinter sects; psychiatry has turned the poor over to State hospitals. Indications are that while the churches have been emigrating to the suburbs, the recent in-migrants to the center city slum areas have no religion whatsoever. The difference between the two positions is that psychiatry has managed to penetrate the new technological class, the university, the military, and the government, while the church has been paying little attention to these areas. By thus remaining in the social, governmental, and technological mainstream, psychiatry has maintained enough flexibility to remedy some of its mistakes in not caring adequately for the poor. The community mental health movement is psychiatry's answer to its social shortcomings.

The underlying philosophy in community mental health is simple: psychiatrists must understand the mental health problems of all cultural and subcultural groups in America, they must make appropriate services available to people in need of them, and they must develop ways of preventing widespread mental illness. Each center must make its services known to the people in its catchment area, coordinate all existing psychiatric activities in that area, and attempt to make available all necessary psychiatric services to persons in that area.

Many Christian denominations show growing interest in the urban church. The values, goals, and problems of urban church activities have about the same relationship to organized religion as those of the community mental health movement to psychiatry. Both the church and psychiatry have ignored such social and individual difficulties as alcoholism, drug addiction, violence, and sexual perversion.

What can the church and psychiatry do to fight poverty and mental illness? A joint attack on the problem of poverty should be based on research into the life and phenomenology of the lower socioeconomic classes, striving to understand the language style of living traditions, complexities, problems, daily events, and methods of communication of the lower classes. Awareness and comprehension of the fabric of lower-class culture must replace the myth that the poor are helpless, childlike, less intelligent, unable to see the subtleties and complexities of life, and almost without strengths. The poor in this country are on the move. They no longer accept inferior status, and their powerful movements in the direction of middle-class values

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have created the tensions reflected in civil rights rioting. To comprehend these movements and tensions, clergy and psychiatrists must understand racial integration, equal employment opportunities, school dropouts, delinquency, the welfare and medical problems in poor areas, and the consequences of these phenomena. They also must consider the effects of outsiders solving the problems of poverty for the poor.

The community mental health centers and the church must unite in specific ways. The community mental health center should provide a consultation service for all churches in the area. It should hold educational courses, seminars, and discussions for local clergy. Each center should have at least a part-time clergyman on its staff who would serve as liaison with all religious denominations in the community, encourage the clergy to become referral sources to the center, and develop religious resources for use by the center. Religious groups should take a more active role in the problems of the aged, teen-agers, and the fractured family.

The churches should recognize the importance of the community mental health movement and work with centers as they develop. The churches could be of inestimable value in increasing community support and helping to provide the space, money, and personnel to staff the centers. Each denomination should appoint a clergyman as a representative to the center in its area. In lower socioeconomic areas, there should be a Protestant, Catholic, and Jew on the board of advisors of each center.

Insofar as possible, each clergyman and religious leader should become active in the promotion of mental health and prevention of mental illness. By taking courses in pastoral counseling, sociology, anthropology, group dynamics, and other areas, a clergyman can broaden his knowledge of human dynamics. He can learn to distinguish serious psychiatric illness from temporary disorders and get help for those who need it. He can be a more effective counselor when faced with such problems as divorce, marital infidelity, sexual perversion, alcohol and drug addiction, and other problems that come to his attention.

Although the psychiatrist is often reluctant to accept help from other professionals, clergymen can teach him that surveys, psychodynamics, endless drugs, and group therapy will not tackle the basic problems of a slum community. For the slum is a noncommunity, defined as a place that everyone wants to leave. The American slum has even been abandoned by God. Phenomenological research by clergymen into the horror of urban decay and slum proliferation might be more fruitful than sociological and anthropological research.

Miraculously, community mental health has been not only supported but initiated by the political powers in the nation. The community mental health movement can be an effective vehicle for all denominations to become an integral part of the social mechanism for dealing with poverty and enriching the lives of those we have neglected for so long.

The Sociology of Suicide Prevention: Policy Implications of Differences Between Suicidal Patients and Completed Suicides

RONALD W. MARIS

It is remarkable how stable the suicide rate has been in twentieth century America. Regardless of how one explains this stability, two implications stand out: suicide is an increasingly important factor in the death rate and suicide is not being prevented. Here it is hypothesized that suicide prevention efforts have failed because suicide prevention agencies, physicians, and public health workers do not contact highly suicidal persons and, thus, have formulated policies based on experience with non-suicidal or low lethality populations.

To test the hypothesis that suicide prevention center patients and completed suicides are different, a 67-item schedule was administered to 150 subjects in New Hampshire. Since the major suicide prevention agency is the State hospital, 75 consecutive admissions for suicide attempts or problems were interviewed. The subjects were probably more seriously suicidal than the average suicide prevention center client. The same schedule was given to the coroner's informant on suicides completed in 1964 or 1965. Because many informants had moved, it was necessary to use a mailed questionnaire. Of the 153 questionnaires mailed, 95 were returned. Of these, 20 were unusable, leaving 75 responses. When the informant requested it, an interview was conducted. Generally the information from the questionnaires was more complete than that obtained from the patients.

Of the 67 items, 18 of them distinguished suicidal patients from completed suicides. Patients and suicides constitute different populations. This is an important but hardly startling conclusion. What is interesting is how and why the patients differed from the suicides. Explanatory analysis with only 150 cases and dichotomized variables is dangerous, since it is statistically unwise to control simultaneously for more than one variable. Given that the present research is exploratory and meant only to hint at possible interaction effects, more good than harm should result from suggesting rudimentary causal chains.

Only 43 percent of the patients were male, while 76 percent of the suicides were male. Eighty-one percent of the serious suicide attempts were by males but only 42 percent of the non-serious suicide attempts. The lethality of the method of attempting suicide is related with suicide; the more lethal the attempt, the greater the probability of accomplishing suicide. These data suggest a possible causal sequence; viz., that the method of attempting suicide contributes to the relationship between sex and suicide. The more males in a population, the more lethal the method of suicide attempt and the greater the probability of completing suicide.

Sex is also associated with the number of years on one's last job, mental health, and mental hospitalization. The job data are biased by the large number of females who never worked and the hospitalization data by the patients' confusion of their present institutionalization with hospitaliza-

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tion prior to the suicide event. For mental health, 40 percent of the males were classified as mentally healthy contrasted with 18 percent of the females. The better one's mental health, the greater the chances of completing suicide; the poorer one's mental health, the greater one's chance of being a suicidal patient. Forty-eight percent of the suicides were mentally healthy; 17 percent of the patients were mentally healthy. Mental health in itself does not interpret the relationship between sex and suicide. In the New Hampshire data, the more females, the poorer the mental health; the poorer the mental health, the greater the number of suicide attempts; and paradoxically, the more suicide attempts, the less suicide. This paradox is resolved in part by noting that a greater number of suicide attempts is associated with the use of less lethal methods.

What accounts for the patients' poorer mental health? It would appear that home life might be a factor. Fifty-seven percent of the suicides came from normal homes; 33 percent of the patients came from normal homes. It is hypothesized that the more broken homes, the greater dependency needs in later life; the greater the dependency needs, the poorer the mental health. The associations between home life, dependency, and mental health offer no evidence to doubt this causal sequence. It seems that home life and dependency make a slight contribution to the poorer mental health of the patients.

The suicides had poorer communication than the patients. For example, 77 percent of the suicides were visited by friends less than four times in a month immediately prior to the suicide; 61 percent of the patients were visited less than four times. Seventy-five percent of the suicides had read no books in the year before their suicide (this may be a function of age); 50 percent of the patients had read no books in the year before their suicidal event.

It is tempting to conclude that since patients were more likely to have parents living, their relationship with their parents restrained them from suicide. While there is probably some truth in this speculation, age of the suicidal actor is probably more crucial. Certainly, age explains a large part of the correlation between the variables "parents alive" and suicide. Furthermore, age is interrelated with other variables associated with suicide.

One association with age is that of marital status. All persons 45 or older were married, even though 64 percent of the suicides and 24 percent of the patients were 45 or older. Surprisingly, marital status is negatively related to suicide. The more married persons, the greater the number of suicides. Ninety-one percent of the suicides were married compared with 64 percent of the patients. Given the previously documented prophylactic effect of marriage on suicide, it is likely that age explains the association between marital status and suicide.

Age also has a strong negative association with physical health. Seventy-six percent of those less than 45 years old were in good to excellent physical health; 35 percent of those 45 or older were in good to excellent health. Sixty-two percent of the suicides had fair to bad physical health. Only 32 percent of the patients had fair to bad physical health. Thus, the older one is, the poorer one's physical health; and the poorer one's physical health, the greater the incidence of suicide.

Physical health and age both related to the lethality of the method of suicide attempt. Sixty percent of those 45 or older used lethal methods, but

only 31 percent of those under age 45 used lethal methods. The older one is, the more lethal the method used; the more lethal the method used, the greater the incidence of suicide.

The patients failed at their work more than the suicides. Sixty-eight percent of the suicides had been on their last job one or more years, compared with only 27 percent of the patients. Seventy-six percent of the suicides had not been fired from or quit their job two years before the suicide, compared with 41 percent of the patients. Seventy percent of the suicides were considered successful by their friends; 41 percent of the patients were considered successful. Forty percent of the suicides had achieved their life goals, but only 14 percent of the patients had achieved their life goals. These four variables indicate that work failure is associated primarily with being a suicidal patient and work success with completing suicide.

Not all the differences between suicidal patients and completed suicides have been considered. Hopefully, the more salient ones have been. Patients tended to be young, female, and not married. Often they were divorced or separated. They had problems with work; they accomplished fewer life-goals than the suicides. Broken homes were associated with increased dependency, which in turn was related to being not married or unhappily married and to poor mental health. Poor mental health, work, and marital failure all seemed to encourage many nonlethal suicide attempts. The attempts appeared to constitute more of an appeal for help than a wish to die.

As contrasted with the patients, suicides tended to be male, old, and married. They had held jobs longer, accomplished more of their life-goals, and were regarded by others as more successful. Their childhood was relatively normal. Instead of becoming dependent, they became more independent than the patients. A few, highly lethal attempts accomplished their suicides. Thus, the suicides were sick, old men who had been relatively happily married, fairly successful in accomplishing their life aspirations, and who were tired of living. Being independent, having little left to live for, wanting to die, they completed suicide more readily than the patients.

What would a more effective suicide prevention program based on this research include? First, prevention programs must be reoriented to accommodate the life-style of the completed suicide. This necessitates putting more effort into research on a group which has been relatively inaccessible. Given that as many as 98 percent of completed suicides never set foot in a prevention agency and that death certificate data are skimpy and unreliable, the fact is that prevention agencies do not know much about the behavior and attitudes of the group they are seeking to control.

Suicides are disproportionately recruited from lower social classes and have suffered from occupational and financial "skidding." While these characteristics may be more symptoms than causes of suicides, programs could at least help to eradicate these symptoms—action programs tailored to counteract the deprivations of belonging to a lower social class.

Suicides were low in social participation. If the suicide rate is to be lowered, older males must have more social involvement and more communication channels open for them. This raises the possibility of the decentralization of suicide prevention services to predetermined ecological

areas of cities and hints that the notion of a "center for suicide prevention" may be at cross-purposes with the goals of the institution. Perhaps the would-be suicide needs to be aggressively sought out. He must not be expected to come running to a center for suicide prevention and initiate a social relationship with an upper middle-class professional who is a stranger.

It is naive to think many near-suicides will dial a telephone number and ask for help. If any communication media were to be used, it should probably be television. Suicidal types watch television as much or more than nonsuicidal types. Since most suicides are married, a program could be developed to inform spouses of the presuicidal clues (even though not one sufficient condition for suicide is known). Finally, someone could explore suicide rates in communities for the elderly.

Since three out of four suicides have been seen by a physician within four months of their death, it follows that M.D.'s have an opportunity to prevent as many as 75 percent of all suicides. At least, physicians should be informed of presuicidal syndromes. Someone could compare the characteristics of males with terminal illness who suicide with those who die a natural death. After all, most sick old men do not suicide.

Finally, suicides make a small number of lethal attempts. Here, stricter control of firearms would be beneficial. It is well-documented that most American male suicides shoot themselves. And four out of five completed suicides have made at least one prior attempt. Since many nonfatal attempts come to the attention of a professional, this is a unique opportunity to intervene. In other words, 80 percent of completed suicides give concrete, highly visible statements of their intention to suicide.

These, then, are examples of the kinds of recommendations that can be made. More specific proposals must wait on research. One fact is clear—success in suicide prevention is contingent upon reorienting current programs to accommodate the life-style of the completed suicide. Without such changes, there is little hope for lowering the suicide rate.

Acute Psychosis Precipitated by T-Group Experiences

Steven L. Jaffe and Donald J. Scherl

Recently we saw two patients who suffered acute transient psychoses precipitated by an intensive T-group experience. Although T-groups are sponsored by private industry, universities, social service agencies, and nonprofit public groups, relatively little investigation has been done on possible harmful effects.

The first case is a patient who was evaluated for psychiatric hospitalization one day after he left a T-group. He is a 39-year old junior executive who attended a T-group required by his company. At a session on the second day, members of his group began vigorously to interrogate one member. The patient began crying and had a fantasy of killing those who were doing the questioning. He went to his room where he cried uncontrollably.

That night he returned home. He was awakened by dreams that his wife or the T-group leader had rejected him. The next day his wife took him to a psychiatric hospital. He talked rapidly with occasional loose associations and laughed inappropriately. He recalled a childhood homosexual incident and remembered occasions when he had turned down requests for money from his alcoholic father.

The patient had had no previous psychiatric treatment. He was placed on phenothiazine medication and during the next week his affect and thought processes were appropriate. The painful memories of experiences also diminished in intensity.

The second patient is a 24-year-old physicist. His employer suggested he seek psychiatric treatment because he had become anxious and depressed. The employer described him as a "brilliant" physicist who had become unproductive.

He was given medication for sleep and scheduled for another appointment. He was next seen two days before the scheduled appointment, the day after he had attended a weekend T-group. He was brought by a co-worker because he was "acting strangely." He willingly accepted hospitalization. After discharge he returned to our clinic. He was slightly depressed and stated that he could not stand being alone. His thought processes were appropriate and there was no suicidal or paranoid ideation. In reflecting on the T-group experience, he described how he had "faced down" another man, had played a crucial role in preventing a girl from breaking down, and had been in a hypersensitive state after leaving the group. He was referred for individual psychotherapy and has been seen regularly.

Because of our interest in what this patient had experienced during the T-group, we met with the T-group leaders to reconstruct the weekend. The 60 participants were unknown to each other or to the leaders prior to arrival. Each participant was self-selected and had paid a fee.

On Friday evening the patient interacted with men in his group, "baiting" and challenging them. He opened himself to attack and attempted to attack those who hurt him. On Saturday morning, he attempted to relate to women. He stated that he wanted to spank one of the girls. The group "egged him on." He wrestled with the girl but was unable to spank her. Following this, he cuddled up to her and she stroked his head in a "motherly" fashion.

Later he participated in a "micro lab" in which the group members and leaders engaged in physical activities. One activity was to face another person shoulder to shoulder and attempt to push the other person back. He was able to push a man back. Then he performed this with the female group leader and pushed her all the way to

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a wall. She interpreted that he was afraid of his own strength and was "terribly passive." At lunch, both group leaders discussed their concern that the patient "seemed to have poor reality testing and might have a psychotic break." They asked him to integrate his experiences through listening rather than "obtaining more data by further interaction."

On Saturday afternoon and evening the group was supportive to the patient since he no longer challenged anyone, but his reality testing continued to be poor.

On Sunday morning he was tearful and brought up new topics rather than dealing with termination of the group. He asked the female group leader to accompany him home. The male leader discussed with him the possible usefulness of psychiatric treatment and learned that he had seen a psychiatrist. The group leader urged him to return to the psychiatrist. The patient drove home by himself immersed in feelings of anxiety and suspiciousness. After hospitalization, the patient contacted both group leaders reporting to them that he was more "people oriented."

Although T-groups differ as to leadership, structure, and participants, these reports confirm that these groups are capable of precipitating severe psychological reactions and raise questions as to the goals, effects, and results of T-groups in general. Psychiatrists generally see only the failures. Certainly an examination of this highly selected population does not represent a basis on which to examine or evaluate the T-group methodology. Yet contacts with failures of this type have convinced us that some common-sense guidelines might be developed by those offering these experiences. We make the following suggestions:

That participation be completely and truly voluntary.

That participation be based on informed consent with respect to purposes and goals. Participants should be warned that T-groups are not intended as therapy (in the usual sense) nor are they intended for persons who consider themselves or fear they are "sick" or "in need of treatment."

That participants be screened at least by questionnaire and preferably by interview.

That participants understand what types of behavior are permissible during the T-group. Physical interaction, if allowed at all, should be limited to those situations where the meaning of the interaction is clearly understood.

That follow-up for all participants be available to help deal with the group termination. This will also provide data on the frequency and severity of psychopathological reactions and on the types of personalities that are most vulnerable to these reactions.

Psychotherapy as Socialization

Sol Levine

Psychotherapy has been enshrouded in so much wonder and mystique that its similarity to other socialization processes has gone unnoticed. There is coherence within the psychotherapeutic world, a uniformity that can be illuminated by the conceptual framework of adult socialization. The therapeutic process is not to be viewed only in terms of intrapsychic activity, but is to be seen as a reciprocal dynamic learning relationship between therapist and patient, each performing well-established social roles.

When therapy is carried out within clinics, schools, and hospitals, it is subject to the criteria, prescriptions, and requirements of these settings. But in whatever setting therapy is practiced, it has to be viewed from the vantage point of the dominant society by which it is molded and to which it contributes. Psychotherapy varies from one society to another, as is manifest in a comparison of psychotherapy in the United States with that in the Soviet Union. The reasons for becoming mentally ill and the dominant modes of therapy differ for the two countries. Psychotherapy, as an institution, will resemble other institutions within the same society involved in the socialization of the adult. There will often be more similarity between psychotherapy and other institutions of socialization in the same society than there will be between psychotherapy from one society to another.

Another factor that obscures the socialization or resocialization character is that most studies have focused on the therapeutic relationship and have not appreciated the relationship of therapy to its larger environment; nor have they given sufficient attention to how an individual begins to think of therapy as an alternative and how he surmounts the hurdles along a tortuous road until he enters the therapeutic system. With the exception of those who experience acute psychotic episodes, patients do not suddenly emerge and appear in therapy. In much the same way as there is screening and filtering of those who plan to enter a graduate school, a religious order, or a military career, so there is a selective patterning of who enters and is engaged by the therapeutic system.

Persons from lower-class groups are more likely not to receive therapy than are their middle-class counterparts. They are more likely to receive custodial, shock, or physical types of therapy, whereas persons of higher socioeconomic status have a greater chance of obtaining the more verbal and the more psychoanalytic forms.

Therapeutic organizations and individual professionals assess the prospective patient as an input in terms of the contribution he can make to their needs and operations and the degree to which he can permit them to practice their most elaborate therapeutic skills. The acceptance of emotionally disturbed children by child guidance agencies suggests that children whose symptoms match the interests of the staff are more likely to receive service.

The prospective patient or client is also assessed as to his psychological "suitability" for therapy. Individual therapists or the organizational gatekeepers make sure that the applicants

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possess minimal psychological prerequisites. Aside from other functions that may be served by the intake interview, it permits the therapist or organization to measure the applicant's potential to profit by exposure to the therapeutic system. Individuals seeking admittance to therapy must demonstrate that they have sufficient humility, ability to accept criticism, intelligence, education, and verbal ability, and a general capacity to "play the game." One crucial requirement is willingness of the person to admit his deficiencies and inability to deal with life's problems, to accept the superior knowledge and expertise of his therapist and to submit to the latter's direction. Even Alcoholics Anonymous and Synanon make this requirement before taking the prospective patient under their protection.

Entrance into any adult socialization experience requires some break with the past, rejection of previous beliefs, values, and modes of behavior and acquisition of a new orientation. The same is true of psychotherapy. The fact that people awaiting admission into therapy are reported to do as well as those who have undergone therapy has been viewed as evidence to demean the value of the therapeutic experience. Instead, it may be posited that some modifications in the patient may be occurring as a result of anticipatory socialization. He assumes a new stance and accepts the role of the patient. At what point does the individual accept the patient role, and is this accompanied by a more objective view of himself, subjecting his behavior and relationships to critical scrutiny and examination, in part, reliving and even changing them?

The client entering psychotherapy assumes the sick role in the same manner as does the patient who is physically ill. Various means are employed to make the patient dependent upon the physician and compliant with his prescriptions—restricting his activities, making him stay in bed, and depriving him of his usual habiliment. Although patients in psychotherapy are often permitted to function in the outside world, there are requirements such as the use and location of the desk and couch, social distance between therapist and patient, and adherence to time schedules—all of which reinforce the inferior and dependent role of the patient. The patient must learn to accept the limiting and frustrating conditions of the therapeutic situation. The patient discovers that the therapist may not reciprocate such greetings as "Good morning" or "Nice weather;" that the therapist may refuse to acknowledge the patient's gesture to shake his hand; and that the properties that obtain in the social world do not hold for the therapeutic session. The conditions may prove particularly frustrating to persons accustomed to manipulating interpersonal relationships in the outside world.

No matter which method of therapy is used, the therapist is not a neutral and passive entity whose values, behavior, and expectations do not touch the patient. The therapist plays a more active role in some types of therapy than in others, but, as a member of an interaction system, he influences the feelings and behavior of the patient. He teaches and persuades. In most cases he has undergone an intensive therapeutic experience and is committed to the value of therapy. As one of the "elect" who has journeyed successfully through therapy and is sanguine about its usefulness, the therapist is often ideally suited to serve as a role model. Through a whole gamut of signs and

cues, the patient learns to detect the response of the therapist and to discern his approval or disapproval. Soon the patient acquires an appropriate vocabulary, learns to focus on the proper problems, and manages to emulate the therapist and fulfill his expectations and requirements. Dreams, thoughts, fantasies, and interpretations assume a pattern consistent with the theoretical outlook of the therapist.

Our discussion has been confined to consideration of institutional and structural properties of the therapy system, with little consideration of how these properties may contribute to the socialization or resocialization of the patient.

Like other forms of adult socialization, therapy involves a learning experience in which the patient, like the student or inmate, is exposed to and encouraged to acquire information. The content of therapeutic information refers more to matters involving interpersonal relationships.

Another feature common to psychotherapy is concern with effecting change in the patient's self-image, his view toward the world, or his relationship with other people. In superficial supportive therapy there is less probing of personality structure than there is in long-term psychoanalysis. Still, in the continuum of psychotherapy there is dissatisfaction with the response repertoire of the patient and effort is made to modify it.

There are unique inducements in the system of therapy. Patients are encouraged to pursue any topic and to report any thought, fantasy, or social act, however distasteful. Whatever the reactions of the therapist, he attempts, and is trained, to display understanding and equanimity. In fact, the reporting of acts and thoughts that are not in harmony with one's self-image may be interpreted as a sign of improvement.

This freedom to discuss any topic with a therapist who cares, who is concerned, and who is even consistently partial to the patient has no counterpart in any adult socialization setting other than in some religious organizations. The freedom, concern, and support encountered in psychotherapy may represent a treasured experience in the life of myriads of patients. Here may lie the main value and attraction of the therapeutic experience.

Because of some of the structural properties of the therapeutic relationship, and because its emotional potential may range from love to hate, it may for many signify one of the most intimate and meaningful experiences they have ever had. The particular school of therapy appears to be transcended by the power of the human experience that may be common to all types of therapies. Indeed, the most "successful" therapists are not differentiated by their theoretical orientation but by their experiences and personalities.

The therapeutic experience involves group interaction from the simple dyad to the therapeutic hospital. To the extent that the experience is positive, intense, and a thing of value, the therapeutic group to which one belongs has the potential for serving as a powerful reference group, as a psychological anchorage, or a point of reference. The transfer effect of the skills learned in the therapeutic situation is dictated more by the meaning of the group for the patient and the identification he has with it, than by the technique or theoretical assumption of the therapist.

With few exceptions, there are no marked or formally defined states that

connote progress and success. Exceptions may be in hospitals in which patients are sent to a new ward or given more privileges. In general, there are no equivalents of grades or examinations, certificates, diplomas, or graduation ceremonies; yet there are definite rewards and subtle indications of success.

If the therapist feels the patient is making progress, he may call the patient by name. Or he may talk more or give more active and directive cues. The therapist may even pay a direct compliment. If the process is judged by the therapist to be proceeding satisfactorily, he may raise the possibility of termination. Or the possibility that one is not capable of "graduation" can be conveyed if the patient is judged to be "regressing" or reverting to old form.

One "sure" sign that the patient is making progress in some schools of therapy is that he shows better insight into himself and appears to be more aware of the unconscious factors that motivate his behavior. If a patient can manifest emotions that were not part of his repertoire or if he can exhibit behavior of which he was not capable, he and his therapist may express satisfaction. For one patient it may be ability to display anger more openly; for another it may take the form of more accurately perceiving and appreciating the intent and feelings of authority figures.

Even after "graduation," the therapeutic relationship may serve as a base of reference for the ex-patient. He looks back to the therapeutic experience in attempting to cope with difficult decisions and to assess the appropriateness of his reactions to the social world about him.

It is important to underscore that the sociological or social psychological approach to therapy leads to the delineation of different types of subject areas and the specification of different sets of research questions. The sociologist would seek to order the range of therapeutic approaches in terms of some fundamental structural properties. He would ask, for example: the degree to which the patient participates in his own socialization; the degree to which he requires new information, the degree to which others—psychoanalyst, members of the group, members of the hospital, members of Alcoholics Anonymous, and fellow drug addicts and alcoholics—enter into the socialization experience; the degree to which the therapeutic experience resembles situations in the outside world; and the degree to which the patient is encouraged and able to test his learning in the outside world. This orientation may encourage social scientists to view the therapeutic experience as an area for study that permits them to test social science concepts and to build social science knowledge.

Idle Hands and Giddy Minds: Our Psychological and Emotional Unpreparedness for Free Time

ALEXANDER REID MARTIN

The American people have more time at their disposal than all the aristocracies of history. As to the future, the working time of the American people will decrease while their per capita income and gross national product will continue to rise. By 1985, the economic adaptation to this change will eventuate in a 22-hour work week, a 27-week work year, retirement at 37, or some combination of these working patterns.

I refer to the time placed at our disposal as "free time" to avoid the misunderstandings surrounding such terms as "leisure time," "discretionary time," "unstructured time," etc.

History shows that authority always regarded free time as a social problem. Throughout history, when people had free time, we find these prescriptions: "Keep them busy. Keep them entertained. Keep them distracted. Give them bread and circuses." It was said that fear of social upheaval, when peace came and his soldiers and citizenry had nothing to do, led England's Henry IV to advise his son, "Therefore, my Harry, be it thy course to busy giddy minds with foreign quarrels." This led to Henry V's disastrous invasion of France.

For many with time at their disposal these fears provide the determinants for their over-reliance upon and participation in external resources, such as leisure-time activities. These resources are the "bread and circuses" which account for the multi-billion-dollar leisure-time market. As long as inner resources are distrusted, negated, underdeveloped, and vitiated, external sources become indispensable emergency measures to prevent serious maladaptations to free time.

In 1926, Ferenczi presented free time as a psychological problem. In his "Sunday Neuroses," he observed "untimely depressive" maladaptations to this "one free day of the week" which occurred in the "neurotically disposed." Within the next four decades, as free time increased, it was accompanied by a commensurate increase in comparable maladaptations throughout Western culture, giving us today a sociopsychological problem of the first magnitude. What are the psychodynamics involved in this maladaptation to free time? We can equate incorporated external authority with the super ego and can recognize its function as largely repressive. The authority incorporated since childhood by a "neurotically disposed" individual has all the characteristics of a typical authority in a traditional work culture. It is a strict, bargaining, even venal authority, devoid of gracious giving and receiving. It reveals its duplicity by emphasizing and preaching grace and forgiveness but practicing work and propitiation. Such an authority operates on a conditional quid pro quo reward-punishment basis. It is inclined toward absolute, all-or-nothing judgments and adheres to the Talion law which makes it reflexly retaliative. This causes typical "hysterical, self-punishing" psychosomatic symptoms.

The depressive "spoil sport" attitude and the psychosomatic symptoms are relieved when and if the individual makes himself subject to

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one of many actual externalities, i.e., work, family, society, public opinion, sports, the clock, schedules, etc. He reacts compulsively toward these externalities but he never acts. He cannot call his time his own. It belongs to "them" and serves "them" under compulsion and he anticipates rewards; or he defies "them," feels guilty, and anticipates punishment. Compulsive compliance is often turned into a virtue and perpetuated. Covert rebellion against compulsion finds expression in idleness. The individual protects himself from conflict between his compulsions by detachment and alienation which is expressed as boredom, tedium, acedia, deadness, and emptiness.

This gives us five common maladaptations to free time: depressive, psychosomatic, compulsive, covert rebellious, and self-alienating. These are familiar neurotic patterns which usually overlap and may replace each other. They are precipitated but not caused by free time.

Sudden confrontation with free time is an acid test for revealing certain neurotic dispositions. It also reveals some of the specific characteristics of these "neurotically disposed" individuals. For example, Sunday neurotics have to depend on external resources and this eventuates in uncreative adaptation. They show little or no autonomous, inner-directed action, only reaction. They do not use their inner resources. Their acquired resources fail to prevent maladaptation, as witness the individual who, after years of demonstrating abundance and successful use of acquired resources, suffers severely on retirement; or the successful young lawyer who misses his train and with 40 minutes to wait, no newspaper, and nothing in his briefcase to read, has an acute anxiety attack. Contrast this with the individual unexpectedly exposed to free time with nothing to occupy his attention who found this to be an uplifting experience of self-discovery which changed his whole philosophy of life.

I will refer to two inner resources as our innate capacity for effort and our innate capacity for relaxation.

Rather than say that man is born to work, we should say that man is born with an innate capacity for effort. This is autonomous, inner-directed effort, primarily active rather than reactive. This effort brings its own reward and pleasure. That is, pleasure is inherent in activity, whatever its goals and consequences, in contrast to gratification pleasures. Such autonomous effort has a psychobiological rather than a social function. It enriches the personality and serves our basic drive toward enlightenment, greater awareness, and growth of consciousness. Between the third and sixth months of life, the growing individual develops the ability gradually to focus this effort (intention). Autonomous effort characterizes the intentness of the young child building castles in the sand regardless of others, the basic scientist pursuing the truth, the artist expressing himself, unconcerned by glory or monetary gain. Innate effort exemplifies gracious giving. It is in all competition, play, and interplay that serves the purpose of improving and not proving ourselves. What makes one man's work another man's play, and vice versa, becomes clear if we bear in mind that it is not the nature of an activity that makes it work or play, but the extent to which the effort involved is either autonomous or other-directed (allonomous).

Relaxation is a concern of psychiatry and neurophysiology, and the desideratum of psychotherapy. We ac-

cept its significance and function, yet its dynamics and neurophysiological correlates remain obscure. I submit the following: Relaxation is that innate capacity of the whole conscious personality to open up freely to all stimuli and impressions from the inner and outer world. It is autonomous and to be differentiated from the hypnotic state. The personality is not passive, but in action, and may be wholly engaged in this receptive process. It is not the mere absence of effort. The individual lets his body, mind, and emotions have free play. He stops, looks, and listens to "stars and birds, babes and sages with an open heart." Interested in the whatness rather than the whyness of things, he meditates, contemplates, reflects, marvels, wonders, and free associates. Relaxation exemplifies gracious receiving. It does more than restore. It enriches. Many confuse it with idleness, but during relaxation, the individual is open-minded, open-hearted, and has a happy affirmative mood, whereas in idleness, the mind and heart are closed and the mood is irritable, guilty, and negative. Relaxation has different intensities. Its beginning, duration, and intensity are not subject to conscious control, but determined unconsciously when the outer and inner conditions are favorable. There is a dynamic similarity between it and sleep, while the similarity between relaxation and leisure is close enough to regard them as synonymous.

We see manifestations of these capacities all through human biology, from the integrated organism down to individual muscle contraction and relaxation. During early philogenetic and ontogenetic development, the total psycho-physical organism participates in this effort-relaxation cycle. As development proceeds, these innate capacities may find local and independent expression in different isolated parts of the total personality. In babyhood or early childhood, there is total involvement in effort or in relaxation, whereas, in adulthood, mental relaxation is not necessarily accompanied by physical relaxation.

These capacities find expression at the highest creative level of human development. The duration of each creative cycle and its phase is influenced by outer and inner conditions. Creative growth is never achieved through effort or relaxation alone. During mental effort, our thinking is more rational, deductive, analytic, and logical, and we are more concerned with the existence of things. During mental relaxation, our thinking is more non-rational, inductive, synthesizing, and analogical; we are more concerned with the essence of things. In passing from mental effort to relaxation, we shift our perception, as it were, from high power to low power. As our field of consciousness widens to include what had previously been peripheral and subconscious, unifying patterns are suddenly recognized. The dreaming mind and the relaxed mind have much in common. Relaxation is a return to the poetic, ideographic, figurative mind and has been called "renewal regression," functional regression and "regression in the service of the Ego." During mental effort, we are more prosaic and literal-minded. In their complementary relationship, effort is to relaxation what catabolism is to anabolism and systole to diastole.

In the world of work, innate effort is not suppressed, but loses its autonomy and becomes reactive and other-directed. It becomes inseparable from income and prestige and its social value has priority over its psychobiological value. The individual becomes subservient to the authority of gods

of work who buy and sell his efforts. Autonomous efforts which lead to healthy, formative friction with the personal environment are discouraged and punished as insubordination. Thus, man-made patterns, rituals, and rhythms disrupt and displace our natural creative biological rhythms and cycles.

In the work culture, relaxation is suppressed, discouraged, and scorned, equated with idleness, sloth, apathy, and laziness. Its excessive restriction, especially in babyhood and childhood, interferes with an anabolic-process, prevents our opening up to the inner and outer world, and deprives us of vital and essential sources of growth and development.

As free time increases, the work culture will lose its predominant and harmful influence. However, for some time, it will still remain strongly incorporated and continue to create harmful inner conditions. Note that it is not so much the authoritative characteristics of religious, Puritan, or Victorian cultures, but those of the work culture that are incorporated and create the "hypertrophied conscience." It must be emphasized that its strongest influence is primarily upon effort and relaxation, rather than upon sexuality, and interference with their free expression and complementation will prevent wholesome and complete sexual fulfillment. In other words, sexuality exists as a lesser component within the larger orbit of the biological cycle of effort and relaxation.

"Idle hands" and "giddy minds" are terms stemming from the belief that man cannot be left to his own resources because they are nonexistent or destructive. They reflect the shortsightedness of a work culture which has promoted education in the world of work, by the world of work, and for the world of work, and has provided no education for life off the job.

This education for life off the job is a multidisciplinary responsibility, involving all the arts, sciences, and humanities. It necessitates not only academic but psychological, emotional, physical, and spiritual preparedness. Such education should encompass and engage the whole man—not only the literal-minded, rational, logical, deductive man, but also the poetic-minded, non-rational, analogical, contemplative, inductive man.

Deception in Psychological Research

JULIUS SEEMAN

One way that psychologists have sought to construct experimental controls is to devise "fictional environments"—environments that appear to have certain properties but that in fact do not have these properties. A characteristic of fictional environments is that they involve deception. To study deception in research, journals were analyzed for 1948 and 1963. Journals emphasizing "experimental" and "clinical" areas had a relatively low incidence of deception studies in comparison with "personality and social" areas. When figures for the *Journal of Personality* and the *Journal of Abnormal and Social Psychology* are combined, the mean for 1948 is 18.47 percent and for 1963, 38.17 percent. To some degree deception has come to be the method of choice in this area of research.

Use of deception poses formidable pragmatic problems. Many studies assume the existence of a neutral and naive act or some set specified by the experimenter. Validity rests on the ability of the experimenter to explain the variance in subject behavior on the basis of particular experimental variables. Use of deception introduces new variables that may influence the set of the subjects in unspecified ways and introduce behavioral variations unknown to the experimenter.

When a subject has participated in a study using deception he is a sophisticated subject who brings to subsequent studies a variety of personal theories and hypotheses that guide his behavior as decisively as theories and hypotheses guide the behavior of an experimenter. We may be reaching a point where we no longer have naive subjects, only naive experimenters.

In the realm of public policy, the crux of the issue is the conflict between the rights of the individual and the needs of society. Those who justify deception argue that the accumulation of knowledge exacts a price from individuals, and that this knowledge is worth the price. But democratic ethic reflects tensions generated by conflicts between individual and collective good. These conflicts rarely fail to take account of the central position that the rights of the individual hold in our social system. Even where there is collective danger, individual rights have a pivotal position. For example, our laws provide that even in time of war a person conscientiously opposed to military service may undertake civilian service.

What about the ethics of deception? It is possible that the correct position may turn out to be an absolutist position. Such a position would advance the ends-means argument—that the outcome of any process is embedded in the means used. A process that used deceptive means cannot lead to a "good" end.

There is much to be said for such a view. But one does not need to take an absolutist position to have reservations about the ethics of deception. One could argue that there are instances of innocuous deception that have no adverse consequences. This still leaves the question open with regard to other studies. The ethical issue is drawn most sharply in those studies that use noxious deception. Consider the three studies that follow.

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One study was intended to measure effects of cognitive dissonance. Measures were taken of psychiatric patients' reported self-esteem and of the esteem in which they held their nurses. Subjects were those who reported high positive esteem for themselves and the nurses. Subjects were then given rating sheets that had purportedly been made by the nurses. These fictitious ratings showed that the nurses held these patients in low esteem.

The second concerned the effect of persuasive messages on attitudes. Self-ratings were obtained from psychiatric patients on a hostility continuum. Subjects were patients who rated themselves as less hostile than average. These subjects were later given fictitious "profiles" indicating that they were more hostile than average. The subjects were not informed of the deception, nor deconditioned after the experiment.

In the third, the experimenter told a group of college males that they had latent homosexual drives, when no data were collected to support such a statement. The experimenter never bothered to explain his deception on the ground that he might want to use the same subjects later on.

There is a further problem in deception studies. It is said that telling subjects about the deception corrects the situation. But when a person is told that he has been deceived, he may be confused as to when the deception had really taken place. Some deceptions may have irreversible consequences.

I suggest that the deception procedures may be classified as anti-therapy. In the therapeutic situation the therapist tries to establish conditions of *trust, congruence,* and *reality.* He acts consistently in ways that will develop trust in him by the client. This condition of trust is not contrived, but genuine. The therapist becomes a genuine person to the client, a person who is just what he seems to be. This genuine condition is an aspect of the therapist's self-congruence. The therapist's underlying attitudes and intentions are congruent with his outward behavior to the client. The third property is the reality condition. The therapist knows that a disturbed person often behaves in terms of reality distortion. The task of the therapist is to help the client learn how to respond in terms of accurate reality perceptions. Deception studies reverse the conditions and involve conditions of *distrust, incongruence,* and *unreality.*

There is one final consideration. An empirical discipline takes for granted that its primary goal is the accumulation of knowledge. Psychologists have been trained with regard to empirical processes and have learned to value knowledge above all else. I suggest that the ultimate goal of the scientific enterprise ought to be not knowledge but wisdom. Knowledge alone has a neutrality that can be deadly. It can destroy as well as create. If knowledge in psychology is won at the cost of some essential humanness in one person's relationship to another, perhaps the price is too high.

Man and Society: The Inauthentic Condition

Amitai Etzioni

Among sociologists and social psychologists the concept of "basic human needs" is held in low regard. The discrepancies between a person's inclination and that which is socially expected are accounted for by imperfect socialization, inadequate social control, or conflicting social demands.

The counter arguments state that human nature is less malleable than these disciplines assume, that unsocialized beings have specific needs. When social arrangements run counter to these needs, human beings can be made to "adapt" to them, but the fact that adaptations had to be made can be learned from the level of personal "costs" inflicted, such as mental disorganization and psychosomatic illness. Modern industrial society is often depicted as such a frustrating structure, one which causes neuroses, interpersonal violence, and craving for charismatic leadership.

A second set of costs is social rather than personal. It manifests itself in that efforts which must be spent to socialize men into roles or cultures that are unresponsive to basic human needs are higher than those needed to socialize men into more responsive ones. The same holds with regard to the costs of social control, i.e., expenditures required to keep men in frustrating roles are higher than are those required to keep men in less frustrating roles.

Evidence that some social roles and cultural patterns are less "natural" as compared to others may be gleaned from cross-cultural studies which show that certain modes of required conduct generate frustration in many societies. The frustration could not be caused by a specific socialization, cultural pattern, or institutional structure, for these vary greatly. Austerity, for instance, is found objectionable in as different situations as the U.S.S.R. a decade after the revolution, contemporary Israeli kibbutzim, and Catholic orders a generation after their foundation.

The implications of these two views of the malleability of human nature are extensive. By the first view, persons who do not accept the social prescriptions are "deviants." The second view implies that a society is the "deviant" if it sets prescriptions contrary to human nature.

If we ask the extent of responsiveness of present society, and limit our answer to Western societies, a transformation from past stages suggests itself. This is the transformation from scarcity and the alienation generated by instrumentality toward rising inauthenticity of affluence and pseudo-expressive relations. Before this trend can be explored, a note on the place of participation is necessary. Of the many definitions of alienation, the following seems essential: a social condition is alienating if it is unresponsive to the basic needs of men in that condition. Maximal societal responsiveness will be attained under the Utopian condition in which all the members participate in the shaping of all aspects of their societal life.

The contemporary period for industrialized societies has been characterized as one of abundance (at least for the private sector and the "upper" two-thirds of the members). The lower the level of scarcity, the

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lower the extent of irreducible alienation in that the more basic needs of members can be satisfied without necessarily depriving anyone.

When a society lives close to the subsistence level, allocative patterns entail the deprivation of the most basic human needs to some categories or groups of members—baby girls or minorities, for instance. In the age of affluence, reallocation is aimed at creating a society which satisfies the basic needs of all members and does not inflict deprivation of basic needs on any member. Not only can material needs be satisfied, but more time and energy can be freed for expressive pursuits. The mother who need not labor to add to the family's income will find it easier to provide affection for her husband *and* her children.

The difference between earlier societies, it may be argued, is much smaller than we suggest, because scarcity is a state of mind as well as of the economy. For a suburban matron, inability to acquire a new fur may be as frustrating as a Burmese matron's inability to fill her rice bowl. But even if there are no "real" (physiological) differences, and if the status-race has no level of satiation, the reason the suburban matron is caught in a status-race is lack of authentic expressive relations, while the sources of hunger in the Burmese village are at least in part economic and technological. The suburban "scarcity" can be treated by providing for authentic participation; the hunger in Burma can be so treated only to a very limited degree.

The resistance to making affluent societies more responsive to reallocating and to opening the society to extensive participation has both "real" and symbolic sources. This resistance draws on existing privileged power and economic positions, which would be undermined in such a societal change. While there is a rise in and a spread of societal consciousness and the capacity to act politically among the deprived collectivities, there is also an increasing capacity of those in power to manipulate owing to the communication revolution and the growing use of social science, especially in market and voting research. The ultimate manipulation is found in sustaining the legitimacy of a system that is unresponsive to the basic needs of its members, in that it offers a sense of participation—and more broadly, of responsiveness—where there is only a pittance.

In seeking to understand the affluent age, attention ought to focus on the main source of inauthentic participation, the politics of pluralistic, democratic societies. Authentic democracy is assured by the structure of the government interests and by the values of all members. It is asserted that these can find their way into the political give-and-take, out of which consensual policies and acceptable structures emerge. These claims tend to minimize or view as temporary the unresponsiveness of this political system to those significant segments of the population which have no effective vote, the role played by the mass media and the elite in producing endorsement of unresponsive policies, and the fact that the political alternatives constitute a narrow range excluding many options.

Pluralism without substantial equality in power among the political contenders does not provide for a responsive political system. Citizens have a say in accordance with their assets, power, and extent of organization for political action, such as lobbying and

campaigning. Pluralism "works" not via elections, but via private and public interest groups. Administrative policies and major pieces of legislation are "cleared" with the "relevant" groups. In the process those interests which are not organized are neglected. Farm hands, excluded from the minimum-wage legislation in the United States, are a case in point.

Inauthenticity in other areas is frequently reported. Studies of education show the stress which is placed on a uniform personality format, the "rounded personality." This is a format which does not provide for expression of the variety of personality needs young men exhibit, and promotes relations devoid of deep affection and adequate releases. Studies of suburbia have shown the pseudo-quality of the *Gemeinschaft* generated. Studies of "human relations" training programs for management show programs whose aim is to teach supervisory personnel how to provide their underlings with a sense of participation in decision-making without real sharing of power or interest in responsiveness, and labor unions so committed to industrial peace and cooperation that they serve more as a mechanism of downward control than of upward representation of workers' needs.

Inauthenticity in one area sustains that in others. "Rounded" education prepares for pseudo-participation in the realm of work ("don't rock the boat"). Consumer races provide an outlet for products which answer no authentic need, but produce the demand to work in order to obtain them. Inauthentic politics do not provide an opportunity to mobilize for fundamentally different systems, and the mass-culture provides "escapes" which drain protest and which in turn serve to conceal the "flatness" of the mass-society consumption-and-work world.

The effect is a society which is not committing, to which members are not "cathected," one which provides no effective channels for expression of frustrations, grievances, and needs. Hence, the rise of demonstration democracy, as men take to the streets to express, release, or communicate feelings upward. More deeply, the high rate of alcoholism, neuroses, divorce, addiction, and other symptoms seems traceable in part to the non-committing social world. Evidence that lack of involvement is a factor in causing these personal "costs" and societal problems is that when social life becomes more committing there is a decline in these symptoms.

Shifting from a sociological to a psychological focus, the difference between alienation and inauthentic involvement seems to lie in the difference between having a clear and external target for aggression, and keeping aggression in part "bottled up." The "purely" alienated person—barred from voting, joining a labor union, or attending a university—may feel "shut out." He can identify an "enemy" and release his frustration by anger and physical violence against the "bosses," "the establishment," etc. The inauthentically involved person is allowed to vote, to organize, to join, but this does not make the system more responsive to his needs. He has a sense of guilt, because had he not played along, it would have been impossible to sustain the system and he would not have ended up being manipulated.

Rejection is more impersonal and less psychologically damaging in the pure alienating situation than in the inauthentic one. Jews excluded during the middle ages from political and economic power centers could make

a comparatively healthy psychological adjustment by focusing on the in-group. With emancipation, they lowered their defenses and moved closer to the non-Jews. When rejection came, it was more damaging to self-identity and emotional security. Similar experiences are now the fate of educated Negroes in the United States. Much more needs to be found out about the differences in the psychological problems and dynamics of persons who live in these two kinds of social conditions. Are there differences in psychosomatic illness? Do alienated persons have more speech defects while inauthentic ones have more asthma and ulcers? Etc.

What are the conditions under which alienation and inauthenticity may be reduced? In part these are "structural" conditions, as for instance those under which a more equal distribution of political power among the members of society can be brought about. Here the question is: does not the very structure of inequality which generated excluded and underprivileged groups also prevent their effective mobilization for social change, which such a redistribution of power would constitute? The answer seems to be that while the existing structure does make it more difficult for some groups to mobilize themselves, other factors prevent control from being water-tight. The spread of education and the unbalanced upward mobility of those which gain admittance are among these factors.

There also are psychological factors. The fear to challenge the existing social structure has some roots in the reality of earlier periods or present ones (e.g., where political activeness causes loss of one's job, land, or life); but it may be magnified because of internal weakness or lack of a tradition of collective action.

Attempts by those who share similar fears, under-privileged statuses, *and* the social sources of alienation to confront their difficulties serve to reduce the inauthenticity by marking true opportunities for participation and by pointing out false ones. They then serve to make the system less alienating by promoting some reallocation of resources and power, which in turn makes society somewhat more participatory and responsive. Whether this leads to a continual reformation of society is too early to answer. In either case, should mobilization of the uninvolved lead to a gradual transformation or showdown, inauthenticity—the mark of the affluent society—will be much reduced.

A more inclusive discussion of this subject will be found in *The Active Society* (Free Press, 1968) by Amitai Etzioni.

Physiological Parameters of Morphine Dependence in Man—Tolerance, Early Abstinence, Protracted Abstinence

W. R. Martin and D. R. Jasinski

One pernicious aspect of addiction to opioid analgesics is the tendency of the addict to relapse following treatment. During studies of physical dependency on morphine in the rat, it was observed that the abstinence syndrome had two phases and that the second phase persisted for six months or more following withdrawal. These observations suggested the hypothesis that dependence on morphine can induce changes in the central nervous system that persist for many months following withdrawal which will give rise to altered physiological function, an altered psyche, and drug-seeking behavior. To partially test the relevance of these findings in man, seven subjects were studied through a cycle of morphine dependence. A second purpose is to show that chronic administration of morphine in man produces physiological alterations that persist throughout long periods of intoxication.

The seven subjects were male Negroes serving sentences for violation of Federal narcotic laws at the Clinical Research Center, Lexington, Kentucky. A thorough history was taken and physical examination performed on each patient. Laboratory studies included a chest X-ray, EKG, liver profile, blood studies, and urinalysis. All subjects had histories of sociopathic behavior and had personality and character disorders but no evidence of major psychiatric or physical disorder.

Subjects ranged in age from 29 to 47 years, had been using narcotics from 14 to 20 years and had been in the hospital from five to 17 months. They resided on the wards of the Addiction Research Center throughout the study which lasted over 74 weeks. Supine and resting systolic and diastolic blood pressure, pulse rate, respiratory rate, rectal temperature, and pupillary diameter were measured daily. Liver function and blood tests as well as chest X-rays were repeated periodically.

The study was divided into three phases: After a period of acclimation to the ward, control observations were taken for seven weeks. Subjects participated in respiratory studies one day each week. They then received morphine chronically for 31 weeks. Morphine was administered four times daily in increasing dose levels until the stabilization dose of 240 mg/day was attained during the fifth week. After remaining on this level for 34 weeks, patients were slowly withdrawn over a three-week period. Although moderate discomfort was experienced by the patients they cooperated fully. Observations were continued for 30 weeks after complete withdrawal, at which time several subjects left the Addiction Research Center in preparation for discharge from the hospital. Intensity of abstinence was measured using the method in which points are given for signs of abstinence (yawning, lacrimation, vomiting, increased temperature, increased blood pressure, etc.). During the pre-addiction, stabilization, and abstinence phases, the sensitivity of the

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respiratory center to CO_2 was assessed.

Diurnal variations of the parameters for which several daily measurements were made were minimized in two ways: Only the 6:00 A.M. observation was used for statistical calculation, and the three daily observations were averaged and analyzed. The nature of the changes and their statistical significance were the same using the two methods. Because the patients' routines on weekends were different from weekdays, this source of variability was minimized by averaging the weekly 6:00 A.M. observations.

Chronic intoxication—Respiratory rate was depressed and pupils constricted throughout the period of chronic intoxication. Both systolic and diastolic blood pressure, pulse rate and body temperature were persistently elevated. During the early part of chronic intoxication, caloric intake was depressed, and there was a weight loss; however, caloric intake recovered to above control level by the fifth week. Mean body weight also recovered to control level by the tenth week and remained elevated above control level until withdrawal 24 weeks later.

Withdrawal—Subjects were gradually withdrawn over a period of three weeks. Beginning with dose reduction, signs of abstinence began to appear. Because the dose of morphine was slowly reduced, abstinence was not at any time severe. The characteristic signs reached their peak during the week following complete withdrawal and included increases in both systolic and diastolic blood pressure, pulse rate, pupillary diameter, temperature, and respiratory rate above control and addiction levels. The changes in blood pressure, pulse rate, and pupillary diameter persisted in a gradually diminishing magnitude until the fourth to the tenth week after complete withdrawal. Respiratory rate remained slightly elevated for over 18 weeks. During the early withdrawal period, there was a marked decrease in caloric intake and a fall in body weight; by the fifth week following withdrawal body weight had returned to preaddiction level. Although caloric intake partially recovered, it did not return to preaddiction level.

About the sixth to ninth weeks, the physiological changes began to assume a very different pattern. Systolic and diastolic blood pressure, body temperature, and pulse rate fell below mean preaddiction values. Pupillary diameter, which had been greater than control value, became significantly less.

This study indicates that there are persistant physiological abnormalities in morphine-dependent men. Some changes, such as miosis, are well recognized; however, we are not aware of studies that have demonstrated that respiratory rate is tonically depressed in dependent subjects. It is important to emphasize that the sensitivity of the respiratory center to CO_2 is also tonically depressed in stabilized dependent subjects even though they are quite refractory to the phasic depressant effects of additional large doses of morphine. The fact that dependent subjects exhibit a modest increase in body temperature has not been reported although the clinical impression has been that the temperature of the dependent addict is at the upper limits of the normal range. The observation that blood pressure and pulse rate seem to be modestly elevated throughout the period of chronic intoxication may be related to the observation that urinary

norepinephrine excretion was also increased during this period and is consistent with the hypothesis that chronically administered morphine may stimulate central sympathetic centers.

The nature of the morphine abstinence syndrome deserves special comment. It has been shown that it consists of two distinct phases. The early phase or primary abstinence consists of increased blood pressure, hyperthermia, mydriasis, and increased respiratory rate. Primary abstinence is further characterized by increased sensitivity of the respiratory center to CO_2 and an increase in heart rate. The second phase or protracted abstinence, which consists of a decrease in blood pressure, heart rate, and body temperature as well as miosis and decreased sensitivity of the respiratory center to CO_2, does not seem to have been previously described in man. It became manifest six to nine weeks after complete withdrawal of morphine and, with regard to certain signs, persisted for 26 to over 30 weeks.

Several interpretations of the data have been considered:

It seems improbable that the changes during protracted abstinence could have been a consequence of adaptation to the experimental setting. There is good reason to believe that aging did not play a significant role in the treatment effect. Since control observations and observations made during part of the protracted abstinence syndrome were made during the months of September and October a year apart, seasonal changes probably were not important variables.

Two features of the experimental design deserve comment. The administration of morphine, as well as its withdrawal, was done on a single-blind basis; however, this was a meaningless precaution for the subjective changes associated with both chronic intoxication and withdrawal were of such a magnitude and so typical that patients and observers were aware of the nature of changes in medication and dose. Use of a saline-treated control group was felt to be impractical. Patients who have received placebo injections for long periods of time become disgruntled, dissatisfied, and uncooperative. It is doubtful that a control group would have helped in the interpretation of the data because the between-subjects' variability was comparable to the treatment effect.

These data indicate that there are similarities between the abstinence syndrome in man and in the rat in that the abstinence syndrome has two phases, an early or primary syndrome, and a protracted or secondary syndrome. Further, the data are consistent with the hypothesis that during the period of protracted abstinence subjects may be hyperresponsive to stresses. This hypothesis may provide a basis for explaining the decreased aversion for the opioid etonitazene seen in the post-addict rat and may be causally related to relapse in both the rat and the man.

New Directions in Treating Narcotic Addicts

HAROLD T. CONRAD

The Lexington Clinical Research Center provides patient care, clinical and basic research, and training in the treatment of narcotic addiction and drug abuse. Formerly a U.S. Public Health Service Hospital, Lexington joined the National Institute of Mental Health in 1967 and was renamed the Clinical Research Center. Since then the Center has undergone changes in its treatment program, basic philosophy, methods of operation, and physical plant. One aspect of these changes has been the active participation of patient-residents. Not only is there a patient government, the Community Representative Council and the Council on Resident Ethics, but patient residents have been appointed to task forces to revamp the structure of the Center.

The Center no longer admits voluntary or prisoner patients, since all patients now enter under the provisions of the Narcotic Addict Rehabilitation Act of 1966. This is a civil commitment law and entrance to the program is through the office of the local U.S. Attorney. Other applicants may qualify as special study cases for treatment and/or research purposes and may include non-opiate as well as opiate addicts. Under the latter category are certain Federal prisoners who are voluntarily assigned to the Addiction Research Center as participants in research programs.

The objective of the program is effective and humane treatment of drug-habituated individuals during the limited period between admission and return to the community of origin for aftercare. A co-equal objective is the conducting of applied research, with a view to understanding and breaking the habituation pattern. Additional objectives are to develop social adjustment, improve citizenship, and encourage a sense of personal worth and well-being. The fact that residents are treated in a research setting does not mean that they are ever exploited for research purposes.

Why did the National Institute of Mental Health redesignate the hospital as a Clinical Research Center? The answer is that current approaches to drug dependence are but a point in historical development, and efforts have had limited success. Rather than assuming that we have the answers we admit that we don't and that carefully controlled research must be expanded. Research and treatment are not mutually exclusive. They will be coordinated so that the one will encourage and reinforce the other. The ultimate goal is, of course, prevention.

The treatment programs have many aspects—psychotherapy, social services, occupational therapy, recreational therapy, vocational assignments, special training, academic and nonacademic education, and general medical, surgical, and dental care.

It would be neither desirable nor feasible to provide individual psychotherapy to each resident. Most residents will participate in group therapy. Some therapists feel that group approaches have unique advantages in the treatment of drug dependency. One-to-one therapy, when considered the method of choice, will be done when practicable.

Condensed with permission of the author from a paper presented at the Second NARA Training Conference, Atlantic City, N.J. on October 23, 1969.

Staff and residents daily experience the phenomena of progress, growth, and development within themselves, one another, and in the field of treatment for drug dependence. Built into the program are means for studying and evaluating progress along a variety of dimensions in order to understand better the total population of our community.

Staff hold that our own attitudes are communicated to residents verbally and nonverbally. When we accept the resident as a person, expect him to find his stay beneficial, and believe that he can change, he senses these feelings and expectations. Such messages help start him on the road to recovery. Rejection and pessimism also become part of the resident's awareness. If those whom he regards as experts expect him to fail, he will usually have the same expectation.

Our goal will be to convey knowledge and principles without dogmatism or rigid adherence to certain approaches or ways of doing things. Awareness of the necessity for changes in coping with the challenge of drug abuse helps us to see that without creative and innovative contributions, stagnation will occur.

As a part of the new rehabilitation program, all residents are expected to participate in part-time work related to the functioning of the Center. Efforts are made to provide experience in self-discipline, adjustment to work situations and authority figures, and the satisfaction of productive activity. Privileges and rewards are withheld from residents who refuse to work.

To maintain a drug-free environment, the Center has a program of routine random urine testing for the detection of narcotics and other drugs which may be illicitly obtained as a result of traffic to and from the institution. This provides a fairly accurate appraisal of the contraband drug problem, decreases the needs for other kinds of security measures, and acquaints the residents with the urine testing procedure required of them during aftercare.

To motivate the residents, attention has been given to the development of positive incentives and rewards for mature behavior, productivity, and progress in therapeutic and rehabilitative activities. They include increased freedom, special social and recreational functions, choice of rooms, and improved vocational opportunities.

The Center will make more use of the grounds, visits into the city, and field trips. Unescorted ground privileges, escorted and unescorted visits to the city for those who demonstrate readiness, and selected trips for small groups are examples of graduated levels of freedom.

Rules and regulations are being modified to allow for positive reinforcement of desirable and acceptable behavior. Patients are allowed opportunities for control of their own behavior. Most of the iron grilles and bars have been replaced by pleasant open areas. Public telephones have been installed on the wards. Day rooms are provided with drapes and carpeting. Patients are allowed to walk on the grounds when they demonstrate their readiness to accept responsibility. Male and female patients eat their meals together, and enjoy social hours, dances, religious services, and picnics together. All this is a far cry from the days when male patients had to face the wall as female patients passed by.

Dehumanizing and depersonalizing procedures instituted to maintain environmental security have been abolished. The "security force" has been reduced and has no responsibility for patient care. The nursing service has

been increased in size, and has assumed responsibility for the patient care units. Residents will be encouraged to improve their environment including their rooms, day rooms, halls, and activity areas.

Development of a therapeutic community does not imply over-permissiveness. Systems of communication and reporting of unacceptable behavior are being developed. This behavior will be dealt with therapeutically rather than punitively. Emphasis will be given to ridding the Center of penal aspects that formerly existed.

Within each unit, the Center will provide intensive therapy on a locked ward to residents who temporarily need restraint because of emotional disturbance or unacceptable behavior. The intensive treatment will be provided by staff who have been working with the resident.

We feel that modification of the organizational structure into autonomous, separate units will facilitate closer resident-staff relationships, heighten esprit de corps, and encourage units to sponsor their own projects. The new structure will be less cumbersome, and time will be saved in starting various endeavors. An unwieldy structure in the past required a waiting period "machinery" to be set in motion. Nearly all matters had to be funneled through channels for approval—and disapproval. Now each unit will be more autonomous, communication will be easier and things will get done.

I will now discuss our Education and Training Sections and the Research Sections.

The Education and Training Sections are new. They are designing, coordinating, and implementing curricula, tailored for personnel and patients, as well as outside groups who want to learn about drug dependence. This section is conducting training programs for the nursing assistants and nurses employed by the Center. Sensitivity training has begun, involving nurses, nursing assistants, security personnel, and staff physicians. These groups are meeting two hours a day, and the results so far have been dramatic. We have completed a two-day symposium for the Veterans Administration. Over 75 professionals heard lectures, panel discussions, presentations by patients, and speakers from Synanon, Daytop, and Phoenix House. They toured the Center and ate lunch in the patients' cafeteria with patient "buddies" as escorts.

This winter we plan to offer a neural science course for psychiatrists of the Public Health Service and other government agencies designed to assist in preparation for psychiatric Board examinations. The course will involve review of neuroanatomy, clinical neurology, neurochemistry, neuropharmacology, and neurophysiology, as well as the history of psychiatry.

We are developing special programs for groups such as county mental health departments, State mental health associations, and the Southern Institute for Police Training.

Vocational training classes for the patient population have begun. Categories included are the following: alteration in men's suits and pattern making, polishing, repairing and waxing of dentures, drycleaning and pressing of men's wearing apparel, bookbinding, shoe repair, plastic laminating, barbering, auto ignition, and microfilming. One patient is receiving training in electronics at the Vocational Technical School in Lexington. Provisions are being made for other students to attend outside training programs.

A course in Comprehensive Negro History and Culture is offered by an

aide on the Women's Service. Another aide is teaching a charm, beauty culture, and fashion design course.

The resident patients have surveyed their entire population to find areas of need and interest for further education. Plans for courses include child care and development, nutrition, health and home care of the sick, housing and management, and family living.

Some patients are voluntarily teaching courses. One is teaching a sewing class; another formed an art class; and a third is teaching reading to fellow patients who are illiterate. Typing, office practice and business English are offered at 7th, 8th, 9th, and 10th grade levels and taught by a teacher from the Fayette County Adult Education Division. Basic courses in medical technology, gross anatomy, and medical terminology are presented for interested personnel and patients.

The Education and Training Section hopes to develop a video tape and closed circuit television studio, with facilities to conduct inservice training programs. Video tape and closed circuit monitoring will be used for sensitivity training groups as well as instruction in group therapy. We have promises of exchange capabilities with other institutions including the University of Kentucky. This will enable us to develop training films on drug dependence, using patients as well as staff. These developments are contingent on reallocating our scarce budgetary resources.

The Research Sections are even newer so their programs consist of plans more than completed projects. The Sections are:

Neurology—This is the newest and smallest. Work will be mainly with EEG measures, probably with patients under different drug conditions.

Experimental Treatment Unit—We had a small ward for barbiturate and amphetamine abusers who were not narcotic addicts. Almost all patients were abusers of barbiturates, half were physicians, and they resembled their colleagues of a generation ago who were narcotic addicts. Only 14 patients were studied, and emphasis was on establishing a research ward, developing methods and recording systems, and training staff. The ward is temporarily closed, and we hope to re-open it to start a project on methadone and cyclazocine maintenance of NARA patients. This will be a collaborative project, in which the Narcotic Addict Rehabilitation Branch in Bethesda and aftercare agencies will participate. We intend to focus on selection questions —which patients choose to enter and which remain. We will do a rigorous check on the acceptability of such programs to patients after return home, when they must report daily for medication. We will be interested in aftercare behavior, with respect to drug use, work, and criminal behavior.

We are planning a self-help program, and hope that it can develop into another experimental unit. We hope that eventually our treatment programs will become experimental units, whose effectiveness can be compared with one another.

Psychology—This is the largest Section, with four units. Our laboratory will use a variety of physiological measures, with initial emphasis on a new approach—changes in pupillary size—as indicators of anxiety and other emotional states in patients in various drug conditions.

A social psychology laboratory will use games—the prisoner's dilemma game to start—as standardized social situations within which drug effects can be examined. There is informa-

tion on effects of social factors on drug use, but almost nothing on the effects of drugs on social behavior, aside from such alleged effects as rape, murder, and crime in general. We know that alcohol can lead to amorous or bellicose behavior, and it seems plausible that different drugs will have different effects. Under laboratory conditions, it should be possible to produce useful information.

Social science—This section is engaged in studies of the addiction subculture, by interview and simulation methods, and studies of the institution as a culture in itself. A sociologist is doing a history of the institution, to identify changes and factors which hastened or slowed them, and to provide a description against which we can measure future changes. An anthropologist has lived with the patients to learn how the institution appears to patients and how it affects them, in unplanned ways as well as planned.

A sociological theory holds that it is not so much the way a person behaves as the way that society reacts to his behavior that determines his behavior. Perhaps being labeled an addict is a factor in determining whether or not, or how quickly, a treated addict relapses. A staff sociologist is examining that hypothesis among others.

Evaluation—An interest of all sections is evaluation of the effectiveness of the NARA program. The Psychology section is collecting a variety of psychological measures, and the developing of new measures on all new patients. The Social Science staff is amassing, through a staff of three interviewers, data on demographic and social characteristics of patients.

Perhaps the most important use of such data is that they may include predictors of outcome in and after treatment, and ways of controlling variables which must be controlled if we are to evaluate the effectiveness of different treatment programs.

In short, the "new Lexington" is committed to the belief that drug addiction can be effectively treated when cooperative efforts are applied and that improved methods of treatment can be developed.

Mental Health and the Law

Recent Cases

State v. Hannon, Howard County (Maryland) Circuit Court, October 8, 1969

The defendant, Hannon, was arrested after he broke into a home and confronted the owner's wife. At the trial in County Court he pleaded not guilty by reason of temporary insanity. Hannon took the stand in his own defense and testified that the night before his arrest he had accidentally consumed LSD at a party when he was handed a soft drink which, unknown to him, had been "spiked" with the drug. He said that he later began having sensual distortions, and blamed them on the hallucinogen. The temporary insanity argument was supported by Dr. Albert A. Kurland, Assistant Commissioner for Research of the Maryland Department of Mental Hygiene, who testified that the defendant "was criminally insane at the time of the alleged crimes because he could make no judgment on his acts." The prosecutor warned the court that if the defendant were acquitted a flood of cases would ensue in which the defendants, claiming accidental intake, would use this defense.

The court acquitted the defendant on the ground of temporary insanity, upholding the defense contention that Hannon was not responsible for his actions. The judge declared that the defendant was not a future danger to himself or to society unless he again goes under the influence of drugs.

People v. Belous, California Supreme Court, September 5, 1969; 38 LW 2167

The defendant, a physician, gave his patient the phone number of an abortionist. The doctor thereafter was charged with violation of Section 274 of an 1850 abortion law which punished as a felony assistance in any abortion "unless the same is necessary to preserve [the mother's] life." The section was amended in 1967 by adding the phrase "except as provided in the Therapeutic Abortion Act." That Act authorized abortions in accredited hospitals when approved by a hospital staff committee of at least three licensed physicians when there is a substantial risk of impaired physical or mental health of the mother from continuation of pregnancy or where the woman is under 15 or a rape or incest victim. Because Dr. Belous was indicted before the 1967 Therapeutic Abortion Act took effect, however, the court had to consider the law as it was prior to 1967. Defendant was convicted and appealed to the California Supreme Court. That court, in a 4–3 decision, reversed, declaring the old abortion law unconstitutional. The court ruled that the old law, making abortion a crime except when necessary to preserve the life of the pregnant woman, was too vague and that it violated a woman's fundamental right to choose whether or not to bear children.

The opinion stated that the statutory phrase "necessary to preserve" is so vague and overbroad that it does not sufficiently satisfy the requirements of the due process clause of the Fourteenth Amendment to the United States Constitution without improperly infringing on fundamental constitutional rights. "The problem caused by the vagueness of the statute is accentuated because under the stat-

ute the doctor is, in effect, delegated the duty to determine whether a pregnant woman has the right to an abortion and the physician acts at his peril if he determines that the woman is entitled to an abortion. . . The inevitable effect of such delegation may be to deprive a woman of an abortion when under any definition of Section 274 . . . she would be entitled to such an operation . . .," the Court said.

The opinion also noted that "[t]he fundamental right of the woman to choose whether to bear children follows from the [United States] Supreme Court's and this court's repeated acknowledgement of a 'right of privacy' or 'liberty' in matters related to marriage, family, and sex." And the Court found no compelling State interest in restricting this right. Abortions may have been so dangerous in 1850 that their prevention warranted the great State restriction imposed, the court declared, but it added that today a hospital abortion is safer than childbirth. In fact, the compelling State interest would seem to be in protecting thousands of California women annually from resorting to dangerous clandestine abortions, which are a very widespread cause of death and severe illness. Finally, the court noted that the State also has no compelling interest in protection of the fetus that is great enough to warrant this invasion of the mother's rights.

What the Court decided was that the validity of Section 274 of the abortion law before it was amended in 1967 cannot be sustained. It is therefore not clear that all abortions are now legal in California, because the 1967 Amendments to the statute, which added the phrase "except under the provisions of the Therapeutic Abortion Act" to the "necessary to preserve" language and set up in that Act an orderly system for hospital abortions in a range of categories broader than life-death emergency, have not yet been subjected to an adjudication. But although the court did not deal with the constitutional issues raised by California's new law, the decision did suggest that the new act makes it easier for a doctor to decide when he may legally perform an abortion. By emphasizing that a woman has a right to decide whether or not she wants a child, the ruling may give California hospital abortion committees the support they need to be more liberal in approving abortions.

The decision provides a weighty precedent for court action in other States and affirms a legal trend in recent years that would make all such intimate matters a private concern beyond the reach of the state. On September 30, 1969, four New York physicians launched an unprecedented attack on their State's archaic abortion law by filing suit in Federal District Court requesting that the New York State law be declared unconstitutional. This suit was in the planning stage for two years, but its filing was prompted by the California Supreme Court decision. In addition to arguing that New York's law is vague and interferes with a woman's fundamental right to choose whether or not to risk the dangers of childbirth or to bear children, the doctors also argue that the law deprives doctors and patients of the right of privacy in the physician-patient relationship. The law suit is sponsored by the James Madison Constitutional Law Institute, the American Civil Liberties Union, and the Association for the Study of Abortion. Suits in other States may well be expected to fol-

low, because the California statute that was struck down is similar to the abortion prohibitions now in effect in 41 states, and these statutes are now constitutionally suspect for vagueness.

Denner v. Chief of Police of West Orange et al., Federal District Court, Newark, New Jersey

The New Jersey chapter of the American Civil Liberties Union sponsored a suit filed in Federal District Court in Newark, New Jersey on August 28, 1969 challenging the State's marihuana statutes. The complaint names as plaintiffs, on behalf of all marihuana smokers in the State, two New Jersey college students convicted of using marihuana, and as defendants chiefs of police of several New Jersey townships individually and as representative of all other local police officials in New Jersey. The complaint attacked the legality of the State's criminal sanctions against the use of marihuana and narcotic registration laws, and sought a declaratory judgment by the court that would strike down relevant State narcotic laws.

Attacking criminal sanctions against marihuana, the suit declared that to include marihuana with heroin and other dangerous drugs was unconstitutional because to do so denied marihuana smokers equal protection under the law. It was charged that smoking marihuana was not dangerous to the user or to society in general. The executive director of the New Jersey chapter of the American Civil Liberties Union said his organization was prepared to offer expert medical and psychological evidence in court to support its contention that marihuana smoking should not be compared to the use of drugs such as heroin. The ACLU contended that the "private use" of marihuana "does not endanger the general public" and is protected from State action by the right of privacy. To classify the users of marihuana with users of physically addictive drugs or ones that can precipitate violent or erratic behavior, such as LSD, was "irrational," the suit contended, because marihuana did not have either result.

The suit also contended that the registration laws were unconstitutional because they denied due process and the right to travel freely. The law, in force since 1952, states that any person ever convicted of a narcotics violation must register permanently with local police and must thereafter carry on his person at all times his narcotic offender registration card. In addition, the law states that a person must re-register within 24 hours when visiting any other community in the State. The suit pointed out that neither alcoholics nor convicted felons were required to register with the local police. Moreover, the suit contended that the State law, particularly in the hands of some police officials, has become a "vehicle for their curtailment of the activities of certain groups . . . rather than any effective mechanism for controlling the narcotics market."

The New Jersey Attorney General is expected to oppose the suit on behalf of the State.

McCord v. State of New York, Court of Claims of New York, August 22, 1969

The wife of the plaintiff had twice tried to commit suicide. Following her second attempt, she was hospitalized at Marcy State Hospital, a public hospital run by the State of New York. Staff there classified her as a "chronic paranoid schizophrenic." Mrs. McCord's reaction to the drug proketazine was so positive that she made a "social recovery." She was put

on the drug in December 1959, and discharged on convalescent care in July 1961. She was required to and did show up at an aftercare center once a month when she obtained her pill supply. When the aftercare center ran out of pills, plaintiff and his wife made several attempts to get them from the center, but failed. They made no attempt to get the drug at the hospital where it was obtainable only from the hospital's research department, not from its pharmacy. Shortly thereafter, Mrs. McCord slashed the throats of her children and the wrists of one child and herself in an attempt to kill her children and commit suicide. Owing to the intervention of firemen all were saved. The husband sued the State on behalf of himself and his three minor children for injuries to them caused by the State's negligence.

The Court of Claims ruled that the State is legally responsible for the actions of Mrs. McCord. The case was tried in two parts. First, the court dealt with the question of the State's liability. Court records showed that doctors at the Marcy State Hospital kept inadequate records on the pills and that psychiatric social workers at the aftercare center had no knowledge of Mrs. McCord's pill situation. The court ruled that the "State of New York failed to use reasonable care and to act in conformity with standard and approved psychiatric and medical practice" in not supplying Mrs. McCord with an adequate supply of pills when she was discharged from the State hospital. The State was negligent, too, in staffing the hospital with an inadequate number of doctors, some of whom were unlicensed, the court added.

The court then decided the extent of damages. The husband's claim for damages was ruled out, the court finding that he previously had gotten pills for his wife and had "breached his duty to return" her to the hospital when he could not obtain pills in February 1962. The claim of the children, howeve., was allowed, as they were adjudged to have been "physically, psychologically, and psychiatrically" injured by the experience.

The material in this section is based on summaries prepared by the Legislative Service Branch, Office of Program Planning and Evaluation, NIMH.

Mental Health News Digests

"Dope Stop" in Arizona

Junior and senior high school students in Maricopa County are taking the responsibility of explaining the dangers of drug abuse to grade school students. More than 1,000 high school students are in the program as Teen Counselors. Training sessions for the Counselors have been given at over half of the high schools in the county. Each counselor visits a grade school class once a month to give the latest information on drug abuse. The counselor stays with the same class throughout the school year, thus operating somewhat like a "big brother" (or sister). As questions come up, the counselors give the answers if they know them; if they do not, it is their responsibility to learn the answer and present it at the next monthly visit.

"Dope Stop," a project of the Maricopa Mental Health Association, is the education function of the Community-Wide Organization on Drug Abuse Control, and is funded in part by the State of Arizona, the County Board of Supervisors, and several cities in Maricopa County.

Mental Health News from Kansas

Two new services are being started at the Area Mental Health Center in Garden City. One is a comprehensive evaluation program, mainly for children, but also useful for adults. The evaluation will take about five to seven hours, and will include a psychiatric interview, thorough psychological testing, and services of a social worker to work with parents to coordinate findings and suggested therapy for the child. The other is a day hospital plan at St. Catherine Hospital to provide partial hospitalization for about 12 patients. They would have opportunity for individual, group, and occupational therapy.

The Southeast Kansas Mental Health Center has expanded its services to include a school consultation program in cooperation with school districts in five counties—Neosho, Allen, Labette, Bourbon and Woodson—for the purpose of early detection and treatment of mental problems of school children.

Mental Health News from Texas

The Texas Board of Mental Health and Mental Retardation awarded additional grants-in-aid to three centers that recently began their first year of operation. The centers are the Wichita Falls Community Center for Mental Health and Mental Retardation, Central Plains Comprehensive Community Mental Health/Mental Retardation Center, and the Midland Community Center for Mental Health and Mental Retardation. The grants were awarded after the Board changed the rules and regulations for community centers. The change allows new centers to receive more than their base allocation during the first fiscal year if they have taken action to acquire a Federal staffing grant. Another modification bases the minimum allocation to centers that operated during only part of 1969 fiscal year on the year's average State grant rather than the average for the final quarter.

The Central Plains Comprehensive Community Mental Health/Mental Retardation Center in Plainview began limited operation in November. The Center serves a nine-county area. It will begin full operation next summer after a mental health building, containing 25 beds, occupational and recreational therapy rooms, treatment

rooms and offices, is completed. Facilities under development include mental retardation services, a halfway house for alcoholics, and a sheltered workshop.

Journalists and their sponsors from 100 Texas high schools recently attended a two-day conference in Austin on drug abuse. The purpose was to help high school journalists to give better coverage to stories about youth and drugs, to acquaint them with facts regarding drug addiction and abuse, and to assist them to communicate better with students through their newspapers.

Several continuing seminars on mental health and retardation problems are underway throughout the State. The Bell County Mental Health and Mental Retardation Center in Belton is conducting a series of seminars for ministers and teachers. A group of Baytown area ministers are attending weekly counseling seminars sponsored by the Bayshore Mental Health and Mental Retardation Center. Informal discussions include counseling techniques and problem sharing; a series of programs was recently begun on specific topics such as suicide prevention, electroconvulsive therapy, and drug abuse. A seminar for ministers in the San Angelo area was conducted by the Mental Health/Mental Retardation Center for Greater West Texas and the San Angelo Ministerial Alliance. Topics included recognition of mental illness, referral sources, marriage problems, and suicide.

The Freud Award

The Freud Award has been established by the Edward L. Bernays Foundation to memoralize Freud by linking his name with social goals and to increase public interest in the social applications of psychoanalysis. The donor, Mr. Edward L. Bernays, is a nephew of Sigmund Freud. The award, which will be administered by the American Psychoanalytic Association, will be given to the author of a book published between May 1969 and December 1971 which makes the most constructive application of psychoanalysis to social problems.

Foundation of Thanatology

The Foundation of Thanatology has been established, devoted to scientific and humanistic inquiries into and the promotion of the application of knowledge to the subjects of dying, reactions to death, loss and grief, and recovery from bereavement.

It will function as a nonprofit, charitable organization to service the fields of psychiatry, medicine, religion, psychology, the paramedical disciplines, social sciences, nursing, social welfare, philosophy, and theology, as well as to assist directly the bereaved.

The purposes are:

As a multidisciplinary organization, the foundation solicits the interest of all persons who are concerned with the subjects set forth, and attempts to be of service to them.

Development of a publications program including "The Archives of the Foundation of Thanatology," (started in April 1969), a scientific-professional-pastoral journal, *The Journal of Thanatology,* beginning next year, an annual review volume, selected collected readings as books, and the foundation transactions.

Sponsorship of an annual symposium with subsequent publication of papers and workshop procedures as multidisciplinary books. The first of these, "Psychosocial Aspects of Terminal Care," will take place next year. The second is entitled "Psychopharmacologic Agents in the Care of the Terminally Ill and the Bereaved."

Sponsorship and direct initiation of a research program in medicine, education, use of pharmacological agents, and nursing and divinity schools, in areas of the foundation's concern.

Information may be obtained from the Foundation's president, Dr. Austin H. Kutscher, Columbia Presbyterian Medical Center, 630 West 168th Street, New York, N.Y. 10032.

Mental Health Developments in New Jersey

Two bills have been signed into law by the governor of New Jersey. One establishes a Division of Narcotics and Drug Abuse Control in the Department of Health. The Division will be responsible for "a comprehensive program to control addictive drugs and to combat the effects of the disease of drug addiction." All programs for prevention, control, and treatment of drug addiction in the Department of Institutions and Agencies and Department of Community Affairs will be transferred to the new Division. The division will direct pilot clinical programs for addicts and will be the clearinghouse for drug reports from physicians, dentists, and veterinarians.

The second measure increases the maximum amount of State aid that can go to a county for mental health services and projects from 25 cents per resident to 60 percent—excluding capital construction—provided the payments do not exceed the 50 cents per resident limit.

In its annual report to the Board of Control of the Department of Institutions and Agencies, the Division of Mental Health and Hospitals foresees many changes in mental health services. Among them are establishment by 1980 of comprehensive community mental health services in all areas of the State, with present hospitals transformed into medical centers with small semi-autonomous sections. The centers would also have research, training, and evaluation functions and be closely related to medical schools. Special facilities for children in three age groups—preadolescent, young adolescent, and young adult—are also proposed.

Mental Health News from New York

A collaborative effort between the local YWCA and Utica State Hospital has resulted in a program of recreation rehabilitation for patients. The patients enroll in weekly sessions for exercising, volley ball, and swimming. Both men and women patients may participate. Through this program the patients are brought into activities in the community and are prepared for continued participation after release from the hospital.

At Rochester State Hospital there is a "telephone therapy service" in the women's alcoholism treatment unit. It began when the unit opened in 1966. Although occasionally the call is the result of a "crisis," usually the callers merely want guidance or reassurance. Some of the callers want information about the treatment program, but most of them have already been in the program and often are calling to let the staff know how they are doing. Some of the calls are long distance. The unit is always open, so anyone can call in at any time of the day or night. The emphasis in the entire service is to maintain "contact."

The Fortune Society

To create a greater public awareness of the prison system in the U.S. today is the basic purpose of the Fortune Society.

When in disgrace with fortune and men's eyes
I, all alone, beweep my outcast state . . .

These lines from Shakespeare's sonnet were the origin of the title of a play about life in prison, "Fortune and Men's Eyes," by John Herbert. After many performances of the play, the audience stayed to ask questions; ex-convicts began to take part. The ex-convicts then found themselves asked to speak before civic associations, schools, and other groups. And in November 1967, a small group of these former inmates organized the Fortune Society, and got the idea for its name from Herbert's play.

The Society is involved in a great many activities. They have included numerous speaking engagements at high schools on crime prevention, drugs and alcohol; weekly meetings with teenage probationers; meetings with inmates in jails and prisons; meetings with probation officers. It has provided clothing for men coming out of prison and food for inmates' families. Job interviews for men coming out of prison are arranged. The Society has opened a store in New York City, employing ex-convicts and selling crafts—jewelry, pottery, paintings, etc.—done by the ex-convicts.

The Society publishes a monthly newsletter, *Fortune News*, which is available on request. The address of the Fortune Society is 1545 Broadway, Suite 612, New York, N.Y. 10036.

Soma Research Association

Soma was formed in 1967 and incorporated in 1969. Its objects are to do research and provide information on the scientific, social, and moral aspects of psychotropic drug use and other physical means and methods of altering consciousness; and to treat and relieve illness of all descriptions.

The current interests of the Association are in the fields of cannabis research and cannabis law reform. The object of the research program is to provide a clear behavioral account of the psychological effects of cannabis preparations, their active constituents and analogues, and to relate the mechanisms of cannabis action to social conditions. Studies will be made, using naive and sophisticated subjects, on the comparative effects of cannabis, tobacco, amphetamines, alcohol, barbiturates, and the major hallucinogens. Cannabis will be studied by means of objective research techniques employed in experimental psychology, physiology, and psychopharmacology.

The address of the Association is Soma Research Association, Ltd, 498 Fulham Road, London S.W. 6, England.

New Journals

Seminars in Psychiatry is a new quarterly with Dr. Milton Greenblatt as editor in chief. Each issue will contain primarily solicited manuscripts on a single topic. Information is available from Henry M. Stratton Publishers, 381 Park Ave., New York, N.Y. 10016.

Professional Psychology is being published at the outset on an experimental basis. Also a quarterly, it will cover all aspects of the profession of psychology; the editor is Donald K. Freedheim. The publisher is the American Psychological Association, 1200 Seventeenth Street, N.W., Washington, D.C. 20036.

A third new quarterly is *Psychological Medicine* to be launched in the fall of 1970 by the British Medical Association, as one of the Association's journals in special fields. It will publish research reports in clinical psychiatry and related fields. The editor will be Dr. Michael Shepherd of the Institute of Psychiatry, London University.

Reality Orientation

Reality orientation is a rehabilitation program for elderly patients with senile dementia and patients with brain damage. It emphasizes bringing the patient out of his isolation and back into his environment. The technique can be used by aides and nursing assistants.

A publication, *Reality Orientation*, has been compiled by Louise P. Stephens and published by the APA Hospital and Community Psychiatry Service. It describes the technique, gives basic principles and guidelines, and presents case histories and results from one program. A bibliography is included. *Reality Orientation* may be ordered for $1.00 (75¢ for 10 or more) from the Publication Services Division, American Psychiatric Association, 1700 Eighteenth St., N.W., Washington, D.C. 20009.

The Retirement Process

A report on conferences on retirement, *The Retirement Process*, edited by Frances M. Carp, has been published by the National Institute of Child Health and Human Development. The conferences were designed to explore research ideas and recommend areas where special attention is needed. Copies (PHS Publication No. 1778) may be obtained for 70¢ from the Superintendent of Documents or a single copy gratis from the NICHD, Bethesda, Md. 20014.

Forgotten Children

The Forgotten Children by R. Margaret Cook describes the lives of 115 children with alcoholic parents. The children, whose ages range between 10 and 16, were interviewed by the social worker who heads the Youth Counselling Service at the Addiction Research Foundation of Ontario.

One 14-year-old says, "father has spoiled every Christmas—he always smashes the tree." A boy tells of putting his mother to bed when she is drunk. And an 11-year-old girl, with two alcoholic parents, says, "I really get scared."

Copies of the 112-page paperback book may be obtained for $1.00 from the Addiction Research Foundation of Ontario, Education Division, 344 Bloor St. West, Toronto 179, Ontario.

Demonstration of Statistical Techniques

A Demonstration of Statistical Techniques in a Mental Health Program is a report of the Western Conference on the Uses of Mental Health Data. It describes the work of a task force of statisticians who carried out a demonstration of what can be done with existing mental health data in a given setting—in this case the Fort Logan Mental Health Center. It was issued by the Western Interstate Commission for Higher Education, Boulder, Colorado.

A New Creed for Psychiatric Aides

Psychiatric aides at the Osawatomie State Hospital in Kansas recently adopted a new creed. It was written by Bea Whetstone, a Psychiatric Aide II, who is administrative assistant for Rush Biddle Section. The new creed is:

I dedicate my services to the rehabilitation of those men and women who have, for a time, lost their ability to adjust to the world around them.

I will maintain an optimistic outlook on the recovery of the mentally ill —strive to help each person accept responsibility for himself to the best of his ability—to use my skills to inspire faith and confidence that will lead to a desire for recovery

and return to the larger community.

I will be constantly alert to create a therapeutic environment which will allow the patients entrusted to my care to attain individual needs and the privilege of self-activity.

Our cultural heritage has endowed us with a democracy that respects the dignity and personal freedom of man; faithful to my trust, may I always give my patients those privileges that are rightfully theirs.

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